Consumer Services Review Baseline Report

For Children and Families and Adult Service Consumers

January 2007

Presented to the
Indiana Family and Social Services Administration

by
Human Systems and Outcomes, Inc.

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Purpose and Scope of the Review

In January 2006, the Indiana Family and Social Services Administration (FSSA), Division of Mental Health and Addiction began a major Mental Health Transformation Initiative. The Consumer Services Review (CSR) is a primary tool for the measurement of the service level component of the results management efforts specified in the Transformation Initiative.

The Consumer Services Review was conducted at the request of the leadership of the FSSA. The purpose was to obtain data and information about the results being achieved for persons being served by the mental health and substance abuse services system. The leadership also wanted to have more information and data regarding the quality and consistency of performance of services provided to individuals with mental illness and substance addictions.

What outcomes are being achieved for persons with mental health and substance abuse problems who are receiving treatment services? How well are persons receiving mental health services doing with respect to safety, daily functioning, and symptom management? Are we keeping children at home and in school learning and out of trouble? Are we supporting adults with mental illnesses to achieve their personal recovery goals, such as work and independent living? How well are treatment practices and supports working for persons receiving services? What actions might improve community mental health services and the results achieved for those receiving services? These questions were addressed in a statewide qualitative review and analysis, conducted over the last nine months, of a sample of persons receiving mental health and substance abuse services. The results and findings regarding these questions are provided in this report.

The report provides a summary of general findings and conclusions resulting from use of CSR protocols designed for use with children and families and with adult service consumers (one protocol for each group). The protocols were used between May and December 2006 in five service regions covering the entire geography of the state, including 30 community mental health center (CMHC) service providers, as shown in **Display 1** on the next page. Three hundred persons receiving services were interviewed and reviewed during this time.

The report is intended for use by the leadership and staff of the FSSA, Division of Mental Health and Addiction, mental health and substance abuse advocates, as well as leaders and practitioners in provider agencies that comprise the mental health and service network within the state.

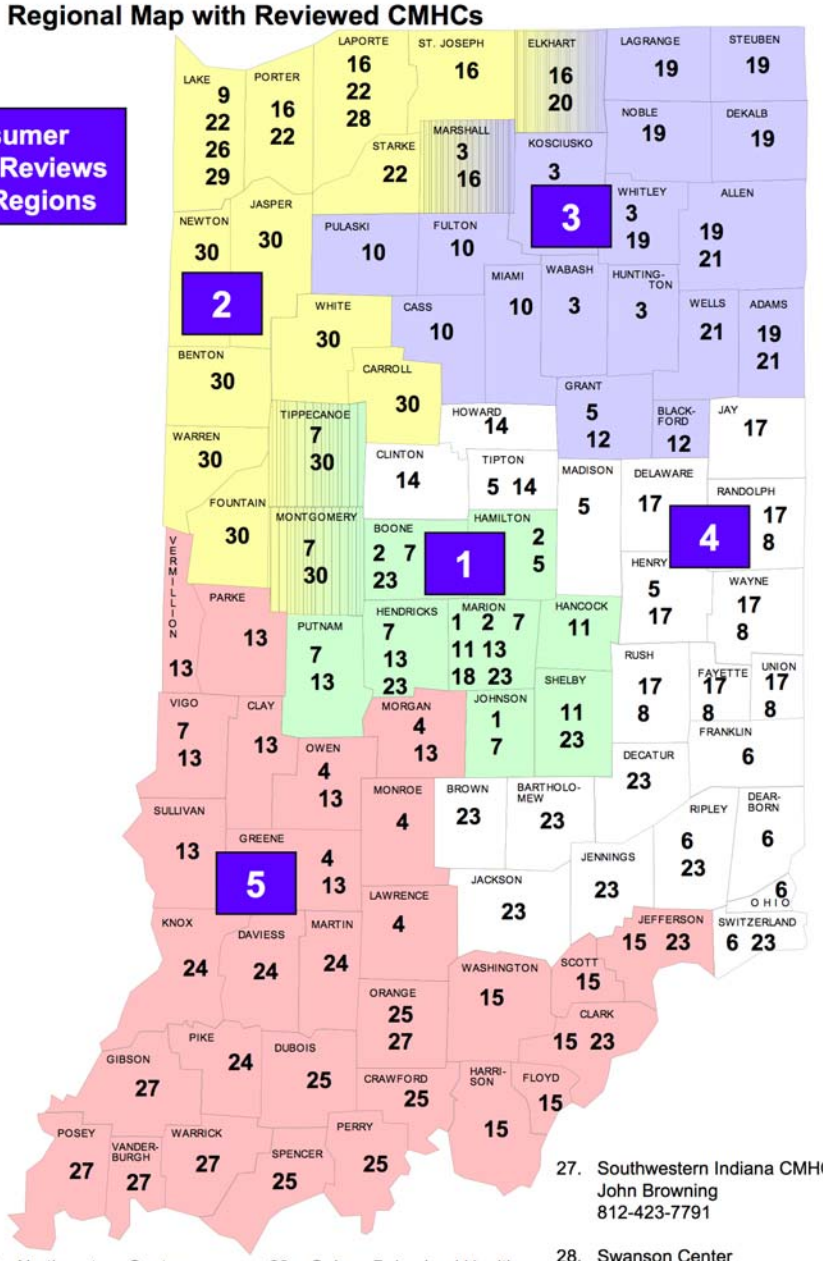
The findings presented represent a point-in-time view of mental health activities and practices for the mental health service system and the local contexts in which mental health services are provided to children, their families, and adult consumers in Indiana. Comments and conclusions offered in the report are based on an independent examination of 156 adults and 144 children chosen at random for this purpose. Focus group and key person informant interviews were conducted with over 250 persons. A total of 1,850 persons were interviewed between the CSR reviews and stakeholder interviews. The input contributed to the CSR ratings and the findings of the report.

Display 1

Consumer Service Reviews 2006
Regional Map with Reviewed CMHCs

1. Adult & Child
   Bob Dunbar
   317-882-5122
2. BehaviorCorp, Inc.
   Larry Burch
   317-587-0500
3. Bowen Center
   Kurt Carlson
   574-267-7169
4. Center for Behavioral Health
   Dennis P. Morrison
   812-339-1691
5. Center for Mental Health
   Richard DeHaven
   765-649-8161
6. Community MHC (Lawrenceburg)
   Joseph Stephens
   812-532-3400
7. Cummins Behavioral Health
   Ann Borders
   317-272-3330
8. Dunn Mental Health Center
   Kay Whittington
   765-983-8005
9. Edgewater Systems
   Danita Johnson-Hughes
   219-885-4264
10. Four County
    Lawrence Ulrich
    574-722-5151
11. Gallahue Mental Health Center
    Eric Crouse, Ph.D.
    317-621-7600
12. Grant Blackford
    Paul Kuczora
    765-662-3971
13. Hamilton Center
    Galen Goode
    812-231-8323
14. Howard Community (Kokomo)
    James Alender
    765-453-8555
15. LifeSpring MHC
    Terry Stawar, EDD
    812-280-2080
16. Madison Center
    Jack Roberts
    574-234-0061
17. Meridian Services Corp.
    Hank Milius
    765-288-1928
18. Midtown CMHC
    Margaret Payne
    317-554-2701

Consumer Service Reviews (CSR) Regions



19. Northeastern Center
    Jerry Hollister
    260-347-2453
20. Oaklawn Psychiatric Center
    Laurie Nafzier
    574-533-1234
21. Park Center
    Paul Wilson
    260-481-2721
22. Porter-Starke
    David Lomaka
    219-531-3500
23. Quinco Behavioral Health
    Robert Williams, Ph.D.
    812-379-2341
24. Samaritan Center
    James Koontz, M.D.
    812-886-6800
25. Southern Hills Counseling
    Joe Kimmel
    812-482-3020
26. Southlake Center
    Lee Strawhun
    219-769-4005
27. Southwestern Indiana CMHC
    John Browning
    812-423-7791
28. Swanson Center
    Elizabeth Kuhn
    219-879-4621
29. Tri-City Comprehensive
    Bob Krumwied
    219-398-7050
30. Wabash Valley Hospital
    Rick Crawley
    765-463-2555

FSSA/DMHA
1-24-07

Five appendices are provided in this report. These appendices are as follows:

- **Appendix A:** Questions Posed in the Consumer Services Review Protocols
- **Appendix B:** Example Summaries from Cases Reviewed
- **Appendix C:** Aggregate Demographic Summary Data
- **Appendix D:** General Rating Scale Definitions
- **Appendix E:** Design Team Participants and CSR Reviewers

Readers are encouraged to review the content of **Appendices A-D** as a basis for understanding the findings and conclusions of this report. The case review protocols used by reviewers were designed to answer the questions posed in **Appendix A**. These questions define the key status indicators for service consumers (children and adults) and the key practice performance indicators for the service systems operating for children, their families, and adult consumers.

The questions that guided inquiry in the review process applied for each child and adult who were reviewed. Special attention should be given to the individual summaries provided for illustrative purposes in **Appendix B**. These summaries offer important perspectives about the strengths and needs of service consumers, how some consumers challenge current mental health practices and local resources, and what services are working and not working for these consumers.

Aggregate reviewer ratings for participating consumers' current status and recent progress, and system performance indicators are provided in **Appendix C**. These summary data present case review results that use a rating scale for measuring status and another rating scale for measuring level of practice performance. Two displays summarizing these scales are presented in **Appendix D**. Information about the persons who composed the CSR design teams and review teams is offered in **Appendix E**.

Practice Transformation Context

The CSR protocols and review processes were designed to work in support of the large-scale, long-term system transformation initiatives in the field of mental health and addiction services that began last year. The transformations are focused on increasing "System of Care" (SOC) practices for children and youth receiving mental health services and on increasing recovery service and opportunities for adults.

The System of Care focuses on family-centered practice that provides for teamwork in the integration and coordination of supports and services across agencies that may be involved in the life of the child and family. The goal is to provide appropriate and necessary mental health services based on thorough assessment and understanding of each child and family individual situation, including coordinating and collaborating with child welfare, special education, juvenile justice, and/or health care services, as necessary to achieve positive outcomes. This approach is aimed at improving functional outcomes for children and families. Many local System of Care initiatives are operating in service areas around the state, and delivery of mental health services in homes and schools has been increasing.

For adult consumers, transformation efforts are aimed at increasing "recovery-oriented practices" that keep consumers functioning in the community while reducing hospitalization and incarceration. Many areas of the state are using Assertive Community Treatment (ACT) Teams (an evidence-based practice model). ACT Teams promote forms of consumer-directed, team-supported services that assist consumers in formulating and achieving personal recovery goals for employment, independent living, and greater participation in community life.

It should be recognized that the transformative efforts by the Division and provider agencies are

occurring at a time of uncertainty and potential change in policy and funding by the federal agency that funds and oversees these services. With these uncertainties come challenges and fears, as well as opportunities and hopes. It is critical for the state to align Medicaid and other funding strategies to support the program philosophy and practice principles necessary to achieve a System of Care for children and Recovery for all persons with mental illness. It is also essential that providers make the necessary commitment to developing consistent practice throughout their organizations that conform to the Practice Principles of Recovery and the implementation of evidence-based practices. The shape of things to come in the processes of transformation will be influenced to a significant degree by the alignment of funding and program requirements, auditing strategies applied by the federal agency, and the commitment of providers to full and consistent implementation of the program practices necessary for System of Care and Recovery implementation.

CSR Methodology

CSR Inquiry Design and Review Activities

The goals of the CSR process are to produce data on practice performance and near-term results and to stimulate and support practice development and refinement. This includes the consistent provision of quality services, enhanced frontline performance of practice strategies and interventions with individuals, and demonstration of effective results so that successful strategies and practices can be affirmed and shared with users in other communities. The CSR process uses a structured protocol, applied by qualified, independent reviewers, to carefully and thoroughly review services and interventions provided by the community mental health centers. The purpose of the review is to determine the status of adults and children receiving services on key indicators and to assess the quality and consistency of system practice in key functional domains for the persons whose services are reviewed.

The CSR process provides deep, rich qualitative information about how well consumers are doing and how well practice activities and services are working for them at the time of the review. Each individual review produces a summary of useful information about the strengths and needs of the consumer being served and about the challenges they bring to frontline practitioners. Cross-case patterns and themes quickly emerge as case stories are presented orally by reviewers to local practitioners.

Quantitative findings are aggregated across cases to produce graphic patterns that help the review team and local participants find and discuss status and performance patterns in affirming good results and in other patterns that point to areas that may benefit from refinement or improvement efforts. Focus group and key stakeholder interview findings are woven together to provide an interpretative context for local program performance findings. Once gathered, CSR results can then be used by state and local program managers and practitioners to plan next step practice development activities, with support provided by Division staff.

CSR Protocol Development

Representatives (practitioners, advocates, leaders, and consumers) of child and adult mental health and substance abuse services from across Indiana assembled in Indianapolis for two three-day design team meetings in January 2006 to create the specifications for the CSR protocols. They considered the best practice models and standards that are currently recommended by the national mental health and substance abuse communities, and then tailored the content to meet the specific requirements and language used in Indiana.

The design process was facilitated by Ray Foster, Ph.D., and Ivor Groves, Ph.D., of Human Systems and Outcomes, Inc. (HSO). HSO staff prepared the rough draft of each CSR protocol. These drafts were provided to the Division in February 2006. The Division staff circulated the draft materials to the CSR design team participants for their review and comment. As there were a variety of design team participants, each having a different local

perspective on the essence of practice, the review and refinement process required opportunities for review and comment. Once a general consensus was reached among the design team participants on the content of each CSR protocol, the participants' comments were sent to HSO in March 2006 for refinements of the CSR protocols.

The draft protocol was sent to the Division in April 2006 and approved for pilot test use in May. Reviewer candidates were recruited by the Division to be trained and to serve in the collection of baseline CSR review information. Training sessions (two-day process) for about 70 prospective reviewers were conducted in May. After the May pilot test, minor language revisions were made to the protocols. A list of the consumer status, progress, and practice performance questions addressed in each protocol is presented in **Appendix A**. **Display 2**, presented on the next page, provides a side-by-side comparison of the indicators contained in the child and adult consumer protocols.

CSR Review Process

For the purpose of baseline data collection, the geography of Indiana was divided into five service areas, including all CMHC provider agencies in the state. The central region, covering Indianapolis and the surrounding counties, was the first region reviewed in May 2006. This event served as a pilot test and began the baseline data collection process that was continued over the remaining four regions. Following a second reviewer training event in August, reviews were conducted for the remaining four regions in September, October, November, and December.

The Division Assistant Director coordinated the set-up of the CSR review activities. CSR coordinators for each provider agency in each service region were identified. Working with the local coordinators via conference calls and emails, each coordinator was prepared to meet the logistical requirements of the CSR review process. Many of the coordinators attended training sessions and participated as reviewers in CSR activities before having to set up local arrangements. These efforts provided for a generally smooth and successful site review for most local mental health agencies.

The review process started with a random draw of service consumers from the Community Services Data System (CSDS) database and included any consumers who were enrolled in the Hoosier Assurance Plan beginning July 2005. A threefold over-sample was performed to account for possible case closures or declines for participation by invited consumers. A list of names (one list for children and another for adults) was provided to each coordinator. The site coordinators facilitation completion of a profile sheet for each consumer and returned a copy to the state coordinator. A stratified sampling matrix that included age, sex, and service utilization, including ACT and SOC, was used. The state coordinator selected consumers for each region and agency for participation and agreement to participate via informed consents. If a consumer was unable or unwilling to participate at the scheduled time, the site coordinator chose a consumer with similar demographics.

A team of qualified and experienced, independent reviewers were recruited to conduct reviews and function as mentors to new in-state reviewers. These 26 out-of-state members of the review team included practitioners, managers, and evaluators from other state and municipal service systems. A total of 77 in-state reviewers completed the CSR team that conducted the 300 CSR reviews summarized in this report. Design team members and other key persons were invited to shadow reviewers and to participate in the group discussion activities. Thus, a total of 103 persons conducted one or more CSR case reviews.

Each of the five service regions provided approximately 25-30 children and 25-30 adult consumers for each review. Once all CSR reviews were completed, using the stratified sampling scheme, it yielded a sample of 156 adult consumers and 144 child consumers for a total of 300 consumers statewide. Each case being reviewed involved several key informants who included the focus child or adult consumer, often family members, service providers, school personnel, and sometimes

Display 2

Indicators Contained in the Child and Adult CSR Protocols

◆ CSR Child Status Indicators

Living & Well-being

1. Safety
2. Stability
3. Permanency
4. Living Arrangement
5. Health/Physical Well-being
6. Emotional/Behavioral Well-being
7. Substance Use

Developing Life Skills

8. Academic Status
9. Social Connections & Supports
10. Lawful Behavior

◆ CSR Caregiver Status Indicators

Parent/Caregiver Status Indicators

11. Parent/Caregiver Support of the Child
12. Parenting/Caregiving Capacities
13. Participation in Service Decisions
14. Substance Use
15. Satisfaction with Services/Results

◆ CSR Child Progress Indicators

1. Symptom/Substance Use Reduction
2. Improved Coping/Self-Management
3. School/Work Progress
4. Risk Reduction
5. Meaningful Relationship Progress
6. Youth Progress To Transition

◆ CSR Child Practice Performance Indicators

1. Engagement
2. Teamwork
3. Assessment & Understanding
4. Outcomes & Ending Requirements
5. Intervention Planning
6. Family Support
7. Crisis Response
8. Resources
9. Intervention Adequacy
10. Intervention Tracking & Adjustment

◆ CSR Adult Consumer Status Indicators

Community Living

1. Safety
2. Income Adequacy & Personal Control
3. Living Arrangement
4. Social Network
5. Satisfaction with Services

Physical/Emotional Status

6. Health/Physical Well-being
7. Substance Use
8. Mental Health Status

Meaningful Life Activities

9. Voice & Role in Decision Making
10. Education/Career Development
11. Work
12. Recovery Activities

◆ CSR Adult Progress Indicators

1. Reduction of Psychiatric Symptoms
2. Personal Management/Substance Abuse
3. Improved Personal Responsibilities
4. Education/Work Progress
5. Progress Toward Recovery Goals
6. Risk Reduction
7. Successful Life Adjustments
8. Social Group Affiliations
9. Meaningful Personal Relationships

◆ CSR Adult Practice Performance Indicators

Planning Treatment & Support

1. Engagement
2. Teamwork
3. Assessment & Understanding
4. Personal Recovery Goals
5. Recovery Planning

Providing Treatment & Support

6. Resources
7. Intervention Adequacy
8. Urgent Response
9. Medication Management
10. Seclusion/Restraint
11. Supports for Community Integration

Managing Treatment & Support

12. Service Coordination & Continuity
13. Recovery Plan Adjustment
14. Culturally Appropriate Practice

friends who helped reviewers by providing important information about the consumer's status, recent progress, and services received. For the 144 children reviewed, a total of 851 interviews were conducted with an average of six interviews per case. For the adults reviewed, a total of 744 interviews were conducted with an average of 4.9 per case. Thus, a total of 2,020 interviews were conducted for the 300 consumers who participated in the CSR activities.

In each of the five service regions, a series of focus group interviews was conducted with practitioners, supervisors, managers, executive directors, and community partners from child welfare, juvenile justice, education, law enforcement, and courts. Over 250 persons participated in focus group interviews during the course of review activities. Adding the focus group participants to the participating design team members, consumers, reviewers, site coordinators, and informants, about 2,500 persons participated in CSR activities in 2006.

CSR On-Site Activities

On-site review activities began on Mondays and concluded on Fridays in each service region.

Review team members traveled to their assigned provider agencies in a region on Monday mornings. Early afternoon, CSR team members convened as a team and received their case assignments, met their mentors/mentees, and were briefed on local services, community needs, and any important initiatives being undertaken by the local provider agencies. Reviewers examined the packet of case materials provided by the site coordinators and readied themselves for their review assignments, including such activities as verifying driving directions and appointments.

On Tuesday, Wednesday, and Thursday, reviewers conducted a CSR review each day. Each review began with a review of relevant case records, including histories, current assessments, treatment plans, and progress notes. This activity helped reviewers prepare for the interviews to follow. Interviews were conducted at the agency offices, schools, homes, and other necessary locations (e.g., jails, sub-acute units) in order to gather information necessary to complete the CSR protocols. Following the interviews, reviewers took time to complete their protocols and prepare notes for a debriefing session. Late in the afternoon of the review day, the reviewer met with local persons (e.g., case manager, therapist, manager, site coordinator) to share what had been found during the course of the interview. This was a time when good practices and results were affirmed and opportunities for refining practice strategies and strengthening services were discussed. Reviewers had been trained on a feedback process that was routinely followed.

Each day, the CSR reviewers completed a data sheet and faxed it into the HSO office for entry into a database so that case review findings were compiled and used at the sum-up session conducted on Fridays. Each Friday morning of the review week, the CSR reviewers assembled at a central location to present and discuss review findings. Oral case summaries were provided by reviewers working in two groups—one for children and the other for adult consumers. Key themes concerning the characteristics of consumers, their special needs and circumstances, local practices, service array and availability, treatment outcomes, and local working conditions for front-line practitioners were surfaced, discussed, and summarized for use in this report. These activities concluded at midday on Friday.

The case-level themes and patterns gathered during these discussions were then connected to the themes and patterns that came out of the focus group interviews by the team leader. This enabled the CSR review team to form a broad and deep context for examining case practices and outcomes in light of local working conditions and service circumstances. These patterns and understandings are summarized later in this report.

Within two weeks following the completion of the site review work, reviewers were required to prepare and submit in electronic form a written case summary following an outline provided in the

CSR protocol. These case review summaries were collected by the state coordinator and shared with participating sites and agencies upon request.

CSR Summation and Reporting

Following completion of review activities in the five service regions, case review findings for the 300 participants were compiled into a relational database and aggregate reports were generated to compile summaries for narrative and graphic presentations. Many of these summaries and graphics are presented as part of this report.

Consumer Services Review Results

This section of the report presents the aggregate findings of the status of the persons reviewed and the ratings of the performance of key practice functions expected by the Recovery Principles for adults and System of Care Practice Principles for children. It should be noted that the sampling and review process does not collect information regarding the timeliness and ease with which persons with mental health conditions are able to enter the system because it does not include persons who are attempting to obtain services but are not yet clients. Access to and timeliness of services was noted as a significant issue in focus group meetings with persons external to the community mental health centers. Individual CMHC review results are not presented because the sample size was too small to generalize the results to each center.

Adult Consumer Review Results

There were a total of 156 adult consumers who were reviewed by CSR reviewers. The displays in this section show data for 156 adults reviewed, unless otherwise specified. Seventy-two percent or 111 of the persons reviewed lived in their own or a relative's home. Ten lived in group homes, 13 were in supported living, and the remainder were in a variety of living arrangements, including five in boarding homes.

Ninety-three had co-occurring conditions, including 35% with substance abuse disorders and 37% with mood disorders. Seventy-one also had co-occurring medical problems that would require coordination with primary care providers. Hypertension and diabetes were frequently identified as co-occurring primary health issues.

The age and gender of the persons reviewed appears in **Display 3**, on the following page. There were 86 females and 70 males. The majority were in the 30-49 age group, with slightly fewer individuals in the 50-69 age group. **Display 4** shows that of the 154 persons for which race/ethnicity was reported, the majority were Euro-American.

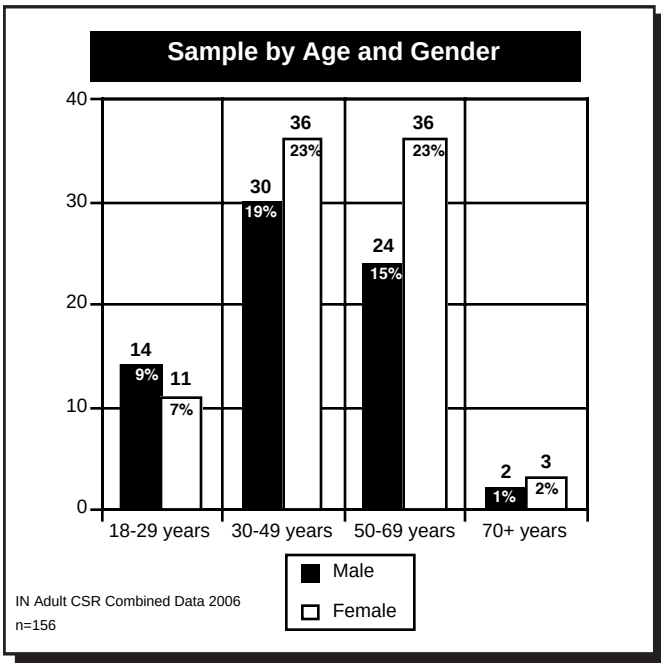
Of the 156 persons reviewed, 128 had been open to services for more than 12 months and 71 had been open for over five years. **Display 5** shows the number and percent of placement changes for the sample and reflects a relatively stable population with regard to living arrangements. The housing stability is also shown in **Display 6**, which shows the time in their current living arrangement. The data show that 62% had been in their current living arrangement for more than 12 months and that 38% had been in their current living arrangement for more than three years. Approximately 50% of the persons reviewed were determined to need a level of care of high intensity community support or higher level of care.

Adult Consumer Review Ratings

Displays 7 and **8** show the percentage of clients who were reviewed that have an acceptable status (rating of 4 or more) on the status domains. Overall, 77% or 120 persons were found to have a minimally acceptable status. The lowest rated status areas are in the domains addressing recovery, such as social network and integration, recovery activities, and education career preparation. The highest rated domains are in living arrangements and in the person's satisfaction with services.

Display 9 provides the ratings of the progress domains. The areas of highest rated progress are in symptom reduction and in reduction of substance

Display 3



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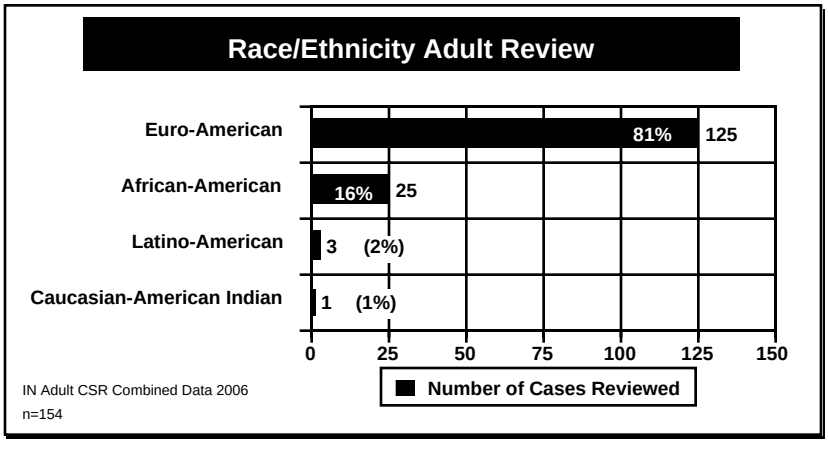
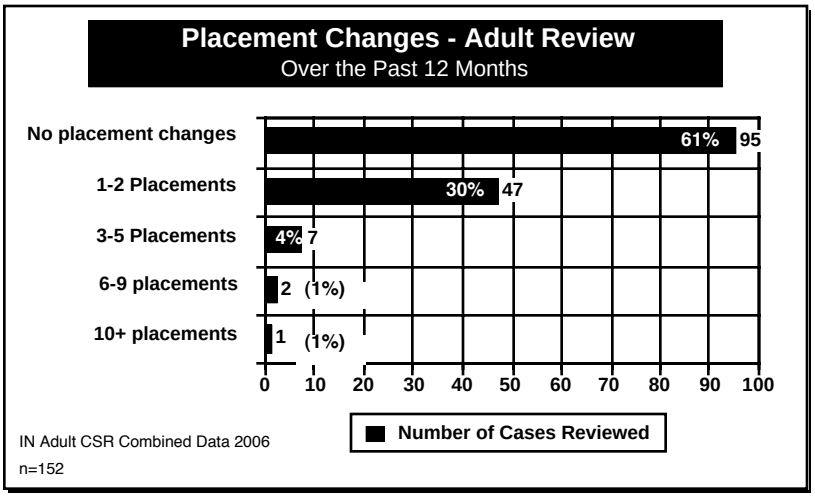


Display 5



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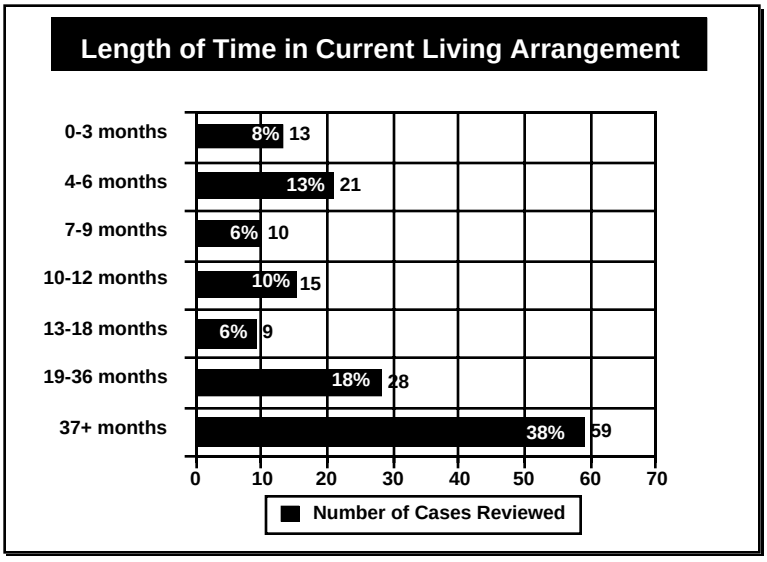
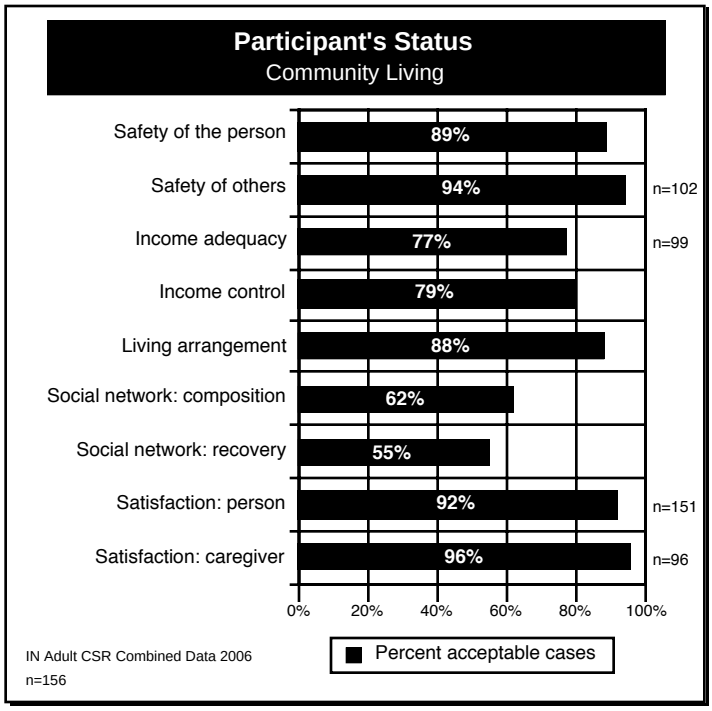


Display 7



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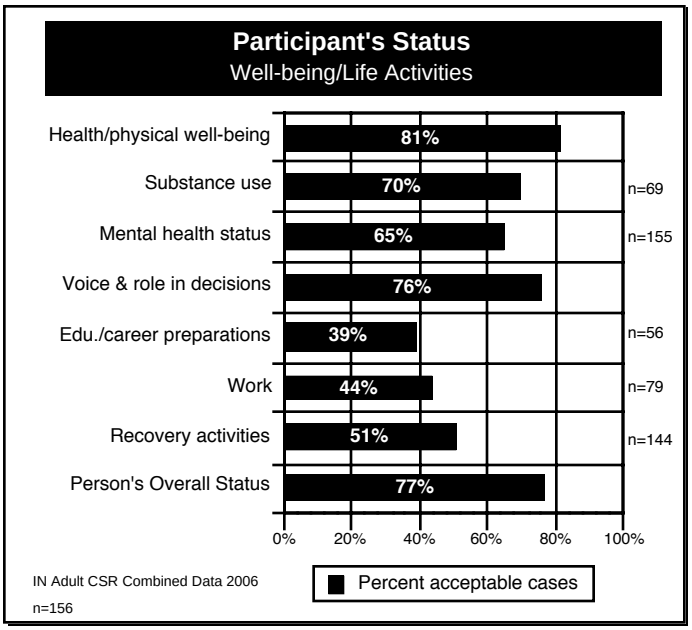
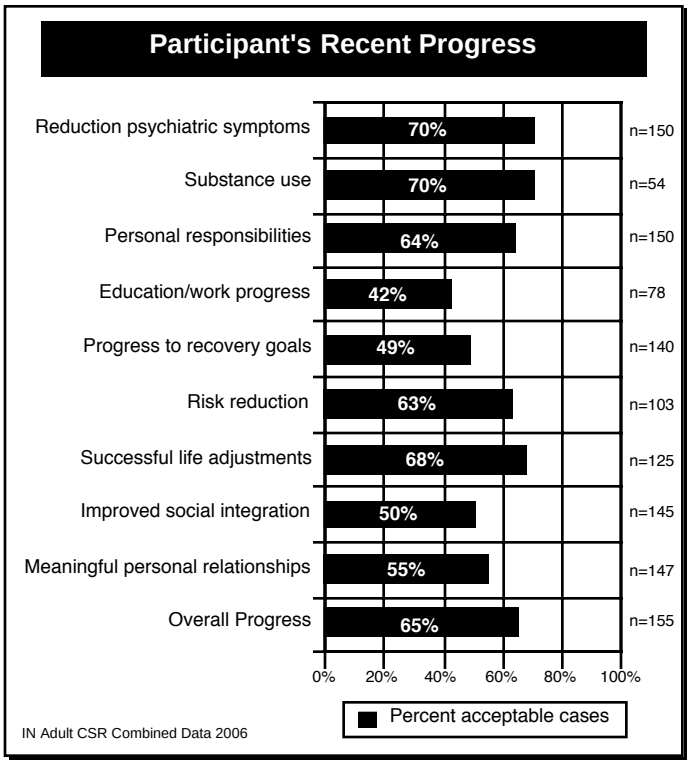
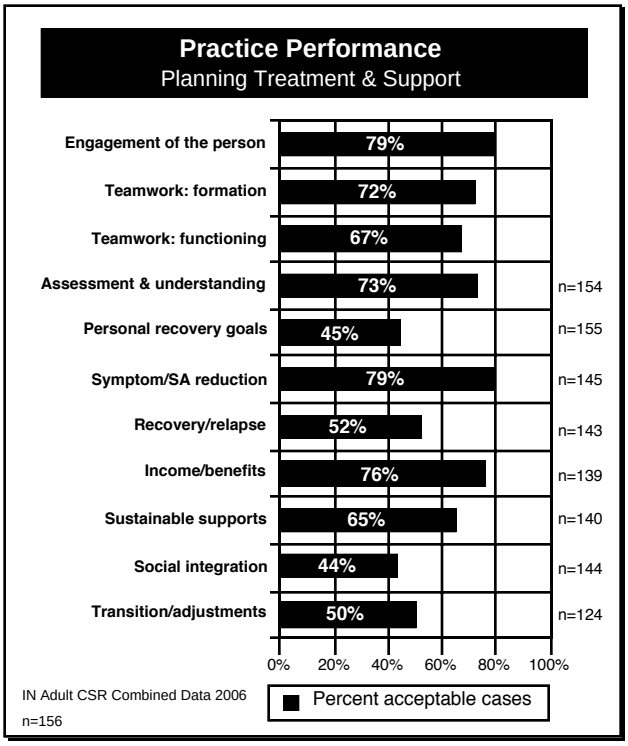


Display 9



Display 10



use. The lowest rated progress domains are in the recovery areas related to having a more full life. Overall, 65% of the persons were rated as having acceptable progress.

Displays 10 (on the previous page) and **11** (on the next page) show the ratings on the domains of system performance. These domains rate the performance of the system on key practice functions, such as engagement, assessment, and service team performance. The highest rated domains are engagement, symptom reduction, medication management, service coordination, and cultural accommodations. The lowest rated domains are in the areas of recovery planning, such as social integration and recovery goals, planning for transitions, intervention adequacy, and recovery plan adjustment. The overall ratings for system performance indicate that 72% of the persons reviewed or 113 people were served in at least a minimally acceptable manner.

Display 12 provides an assignment of each case to one of four cells. Outcome 2 shows the persons who did not have good status but for whom the system performed diligently; Outcome 1 shows the persons who have good status and for whom the system performed diligently; Outcome 4 shows the persons with both unacceptable status and unacceptable practice performance. Outcome 3 shows persons who were found to have at least a minimally acceptable status but for whom the CMHC had not performed with consistent diligence.

Display 13 provides status ratings and system performance ratings for persons who were receiving ACT services (n=27) compared to those who were not in ACT (n=129). For overall performance, 85% of the persons receiving ACT services were rated as receiving minimally acceptable services. The display also shows that these persons were rated as making greater overall progress (81%) and 89% have a current acceptable status. **Display 14** compares the distribution of the ratings of ACT versus non-ACT clients on the 1-6 ratings. The data show that clients served by ACT were more likely to be rated as having high quality services (48%) and fewer were rated with 3 or less.

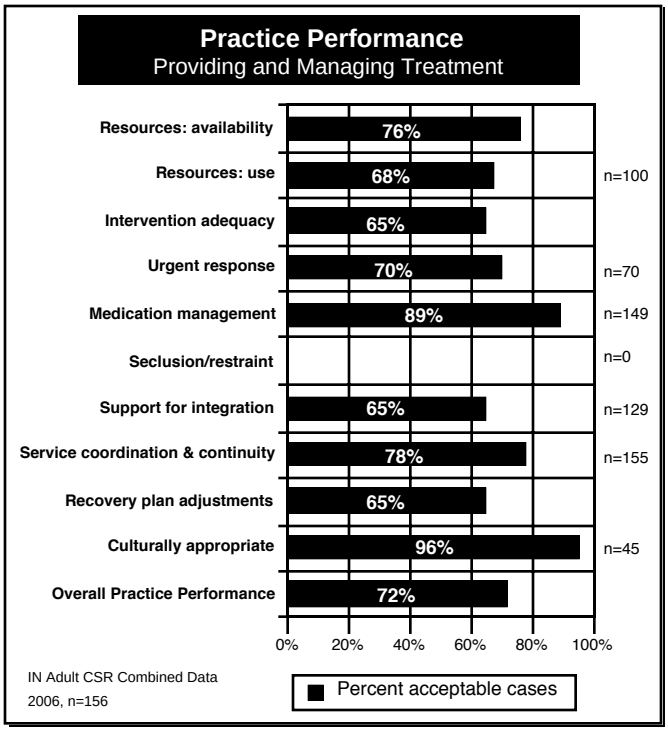
Overall, these data indicate that the CMHC system provides basic care and maintenance on a fairly consistent basis for persons with serious mental illness but is less consistent in addressing and achieving recovery of full life functions. These results reflect a reasonably solid system for adult services for persons with serious mental illness. It also shows that the Recovery approach to assisting persons to have a more full life based on their goals and preferences is just beginning to be implemented. Clients who receive ACT services were shown to be making more progress, and practice performance was rated as more consistently high quality. These data are better than the baseline CSR reviews that have been conducted in other mental health systems and show that with refinement and additional effort in implementing practices to promote greater recovery, the adult mental health system has the potential to be one of the best in the nation in fully implementing Recovery practices with all consumers.

Stakeholders did report issues with delayed access to psychiatrists and some delays in the initial delivery of needed services. These data do not systematically address issues of access or the timeliness of the access to services, such as psychiatrists. They also are not informative about access of persons in corrections in a fully developed system of performance measurement. These data would need to be considered along with data and systematic analysis of service capacity within each CMHC, service utilization profile by each CMHC, and data regarding timeliness of access to services from referral sources, such as child welfare, probation, and the courts.

Child Review Results

There were 144 children reviewed using the children's CSR protocol. The displays in this section show data for 144 children reviewed, unless otherwise specified. **Display 15** shows the age and sex distribution of the sample. There were 94 males and 50 females. The majority were in the 5-9 age group, with slightly fewer children in the 10-13 age group. **Display 16** shows that of the 138 for which race/ethnicity was reported, the majority were Euro-American.

Display 11



Display 12

Adult Case Review Outcome Categories

Status of the Participant in Individual Cases

Outcome 2: Poor status for the participant, ongoing services minimally acceptable but limited in reach or efficacy. **8% (12 cases)**	**Outcome 1:** Good status for the participant, ongoing services acceptable. **65% (101 cases)**
Outcome 4: Poor status for the participant, ongoing services unacceptable. **15% (24 cases)**	**Outcome 3:** Good status for the participant, ongoing services mixed or unacceptable. **12% (19 cases)**

Unfavorable Person Status **23%** | Favorable Person Status **77%**

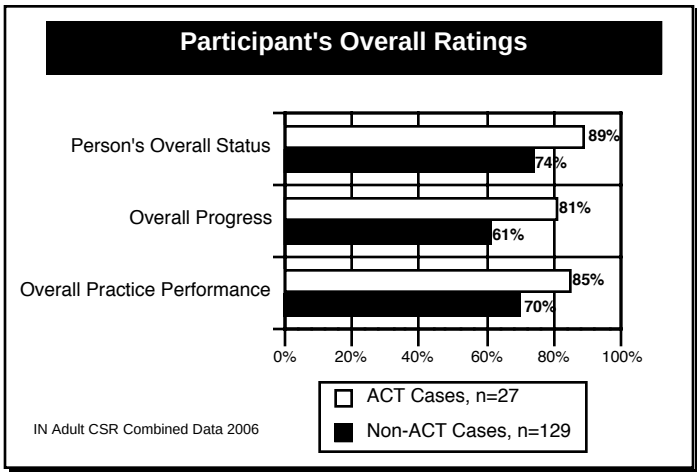
Acceptable System Performance **73%**

Acceptability of Service System Performance in Individual Cases

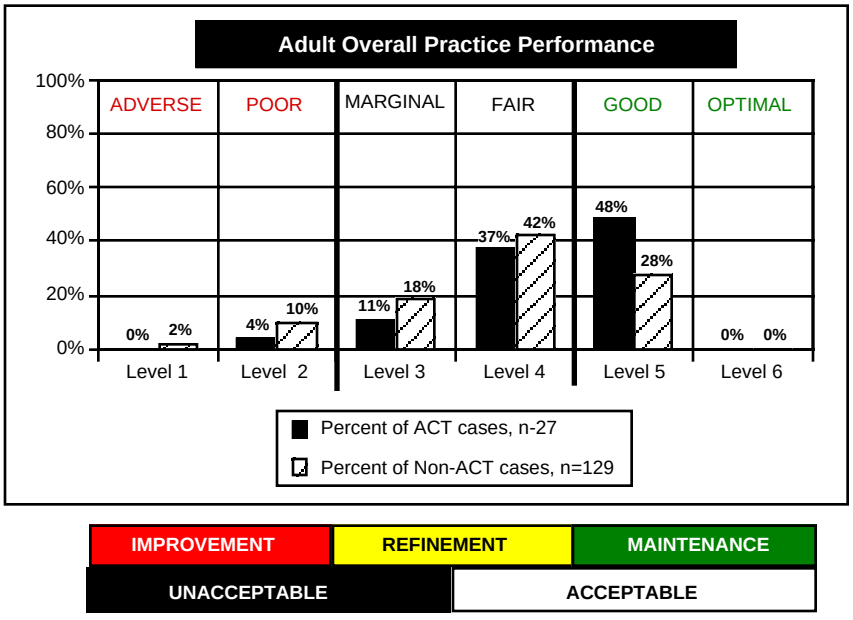
Unacceptable System Performance **27%**

IN Adult CSR Combined Data 2006
n=156

Display 13

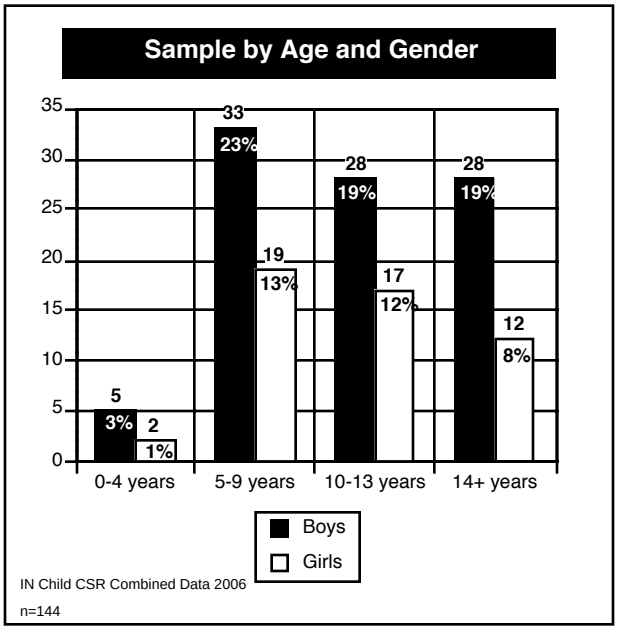


Display 14

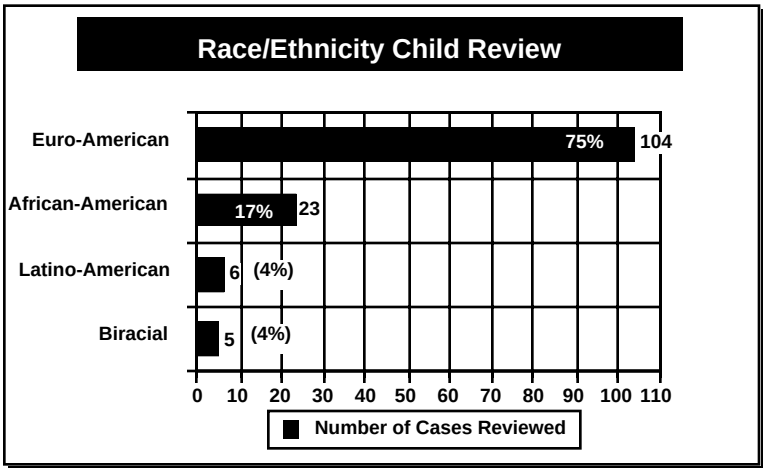


IN Adult CSR Reviews 2006

Display 15



Display 16



Display 17

Diagnosis and Co-Occurring Conditions

	Number	Percent
Mood Disorder	45	31%
Anxiety Disorder	23	16%
PTSD/Adjustment to Trauma	19	13%
Thought Disorder/Psychosis	5	3%
ADD/ADHD	89	62%
Anger Control	30	21%
Substance Abuse/Dependence	7	5%
Learning Disorder	25	17%
Communication Disorder	8	6%
Autsim	8	6%
Disruptive Behavior Disorder (CD, ODD)	55	38%
Mental Retardation	24	17%
Medical Problem	33	23%

IN Child CSR Combined Data 2006
n=144

Of the 144 children reviewed, 121 lived either with their family, in an adoptive home, or in a relative's home. There were 13 (10%) of the children in foster care or therapeutic foster care. The remainder of the children (10) lived in a variety of congregate settings ranging from group homes and psychiatric treatment centers to detention. The most frequent diagnosis was attention deficit disorder/attention deficit hyperactivity disorder. Disruptive behavior disorder was the next most common diagnosis with 55 children. There were 24 children who also were diagnosed with mental retardation. Dual diagnoses were common, with 101 children having multiple diagnoses. **Display 17** shows the children and the number and percentage with the range of diagnosed conditions.

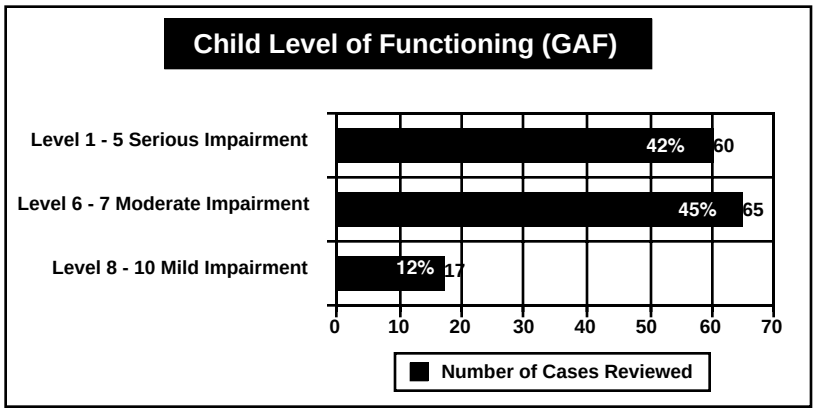
Display 18, on the next page, shows the child level of functioning based on the child global assessment scale. The data show that 60 or 42% of the children were functioning at a seriously impaired level. These children have impairments in functioning in most areas or severe impairment in at least one or more areas. The other 57% of the children had moderate to mild impairments in some areas of functioning, but not in all areas.

Frequent changes in living arrangements/ placements are often found with children with severe emotional disabilities, particularly those in foster care. **Display 19** shows the placement changes experienced by these children in the past 12 months. There were 90 (62%) children who had remained in the same living arrangement over the past 12 months. There were 36% of the children with one or more placements during the past 12 months.

Display 20 shows the educational placement for the 144 children reviewed. Poor school performance and school dropout is one of the greatest vulnerabilities of children with emotional and behavioral disorders. The data show that 42% of the children were in regular k-12 education. The other 58% were in a variety of other educational placements ranging from special education full inclusion to a day treatment program. One child was reported as suspended and another had dropped out of school.

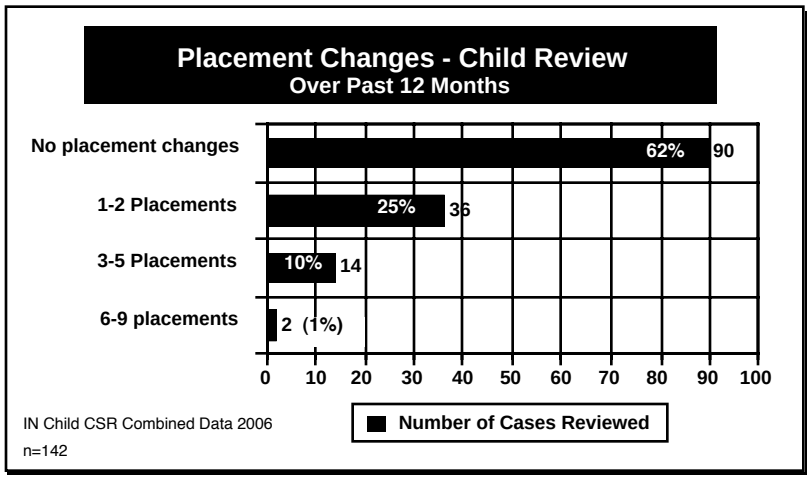
It is well documented that children with mental health disorders are frequently involved with other child-serving agencies. **Display 21** shows the number and percentage of the sample that were

Display 18



IN Child CSR Combined Data 2006
n=142

Display 19



IN Child CSR Combined Data 2006
n=142

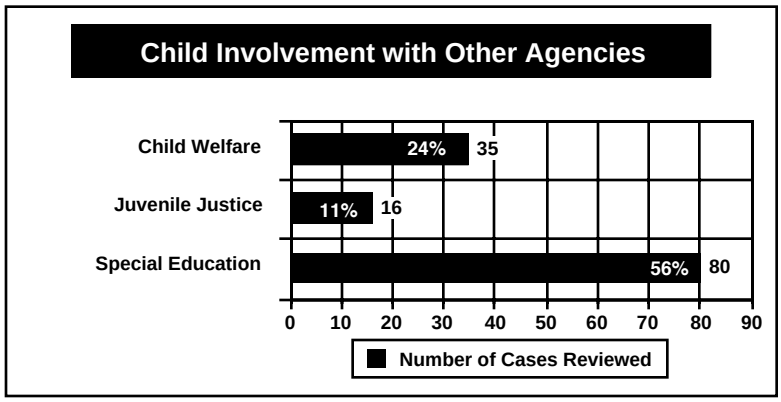
Display 20

Educational Placement

	Number	Percent
Regular K-12 education	60	42%
Full inclusion	11	8%
Part-time special education	35	24%
Self-contained special education	22	15%
Alternative education	6	4%
Vocational education	1	1%
Adult basic/GED	1	1%
Day treatment program	6	4%
Completed/graduated	0	0%
Expelled/suspended	1	1%
Dropped out	1	1%

IN Child CSR Combined Data 2006
n=144

Display 21



IN Child CSR Combined Data 2006
Total Sample 144 Children

involved in other child-serving programs beyond regular education. A total of 111 children were served by one or more other agencies. As can be seen, 35 children were also involved with child welfare and 16 were involved with juvenile justice. There were 80 of the 144 children identified as receiving special education. Additionally, 31 of these children were involved with three or more agencies.

Display 22, on the following page, shows the number of children who were receiving one or more psychotropic medications. The display shows that 25% of the children were receiving three or more psychotropic medications. The use of multiple medications in children should be carefully reviewed to determine if all the medications are necessary. It is prudent to examine prescribing practices to minimize the overuse of medications through poly-pharmacy or psychoactive restraints. **Display 23** shows the length of time in the current out-of-home placement for children for whom this measure was applicable.

Child Review Ratings

Displays 24 and **25** present the ratings for children on the status domains. Overall, child status was considered to be at least minimally acceptable for 78% of the children reviewed. The lowest rated status domains are emotional behavior within the home, instructional engagement and performance, and social behavior. The highest rated child status domains are safety, health status, living arrangements, and permanency.

Overall, caregiver status (**Display 26**) was rated at 88% minimally acceptable. These domains consider caregiver supports and engagement in the team planning and therapeutic process and the degree of satisfaction of the child and parent/ caregiver. These ratings reflect that caregivers were generally involved, supported, and satisfied with the services their child was receiving.

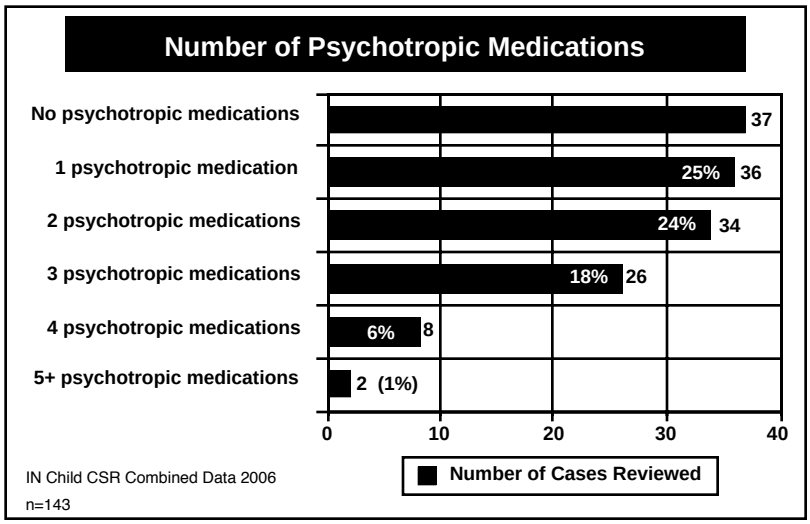
The children's progress (**Display 27**) was, overall, minimally acceptable 75% of the time. The areas with the least progress are in school progress, in improving relationships, and in transitioning to independence. The highest rated progress domain is in improving family relationships.

The children's protocol is based on the practice principles expressed as "System of Care Principles." These include child and family engagement, formation of child teams that involve the child and family and the persons who are intervening in a child's life, such as teachers, counselors, therapists, as well as probation officers and Department of Child Services (DCS) caseworkers applicable to the child and family's immediate situation. It is also expected that the individualized intervention plan developed by the child's team addresses the issues that will keep the child in school and in the home and increase the child and family's independence.

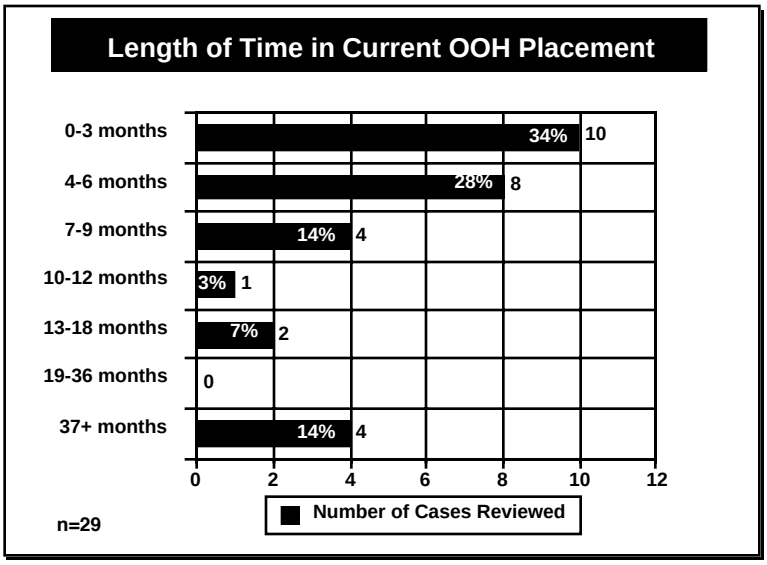
Displays 28, 29, and **30** show the ratings for the domains on system practice performance. The highest rated child system performance domains are child and family engagement, assessment of the child, symptom reduction, and behavioral change. The lowest rated areas are in the domains of team functioning and functional outcomes. Another domain that was rated low was effective planning focus and goals addressing what is necessary to assist the child and family to be able to function more independently and the supports necessary to support the child to maintain progress. Essentially, the plans are focused on near-term symptom reduction and behavior management and less on what it will take to develop and sustain improved functioning at home, in school, and in the community. As a result of these weaknesses, overall practice performance was rated acceptable only 60% of the time.

Display 31 provides an assignment of each case to one of four cells. Outcome 2 shows the children who did not have good status but for whom the system performed diligently; Outcome 1 shows the children who have good status and for whom the system performed diligently; Outcome 4 shows the children with both unacceptable status and unacceptable practice performance. Outcome 3 shows children who were found to have at least a minimally acceptable status but for whom the

Display 22

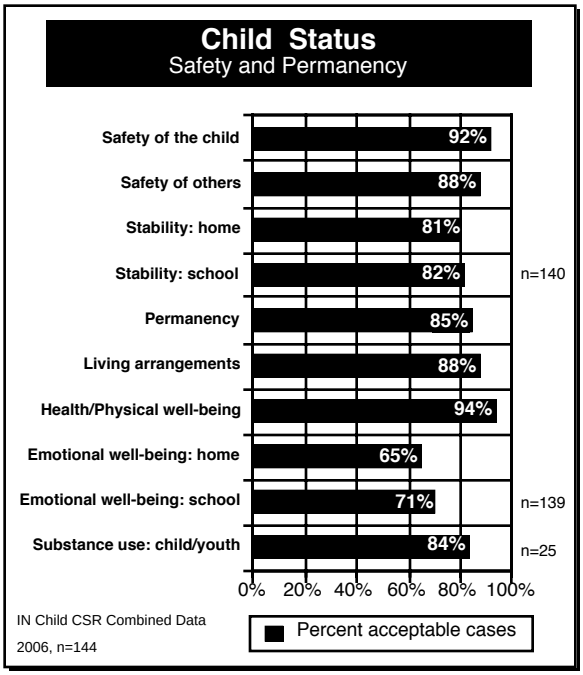


Display 23



IN Child CSR Combined Data 2006

Display 24



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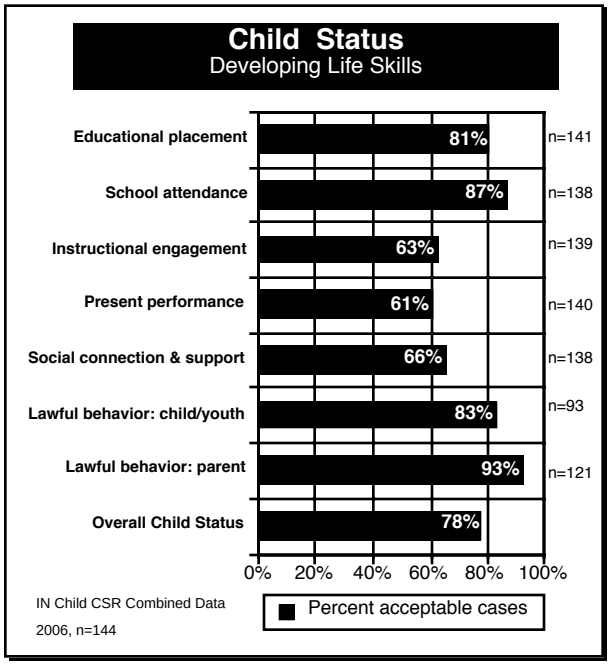
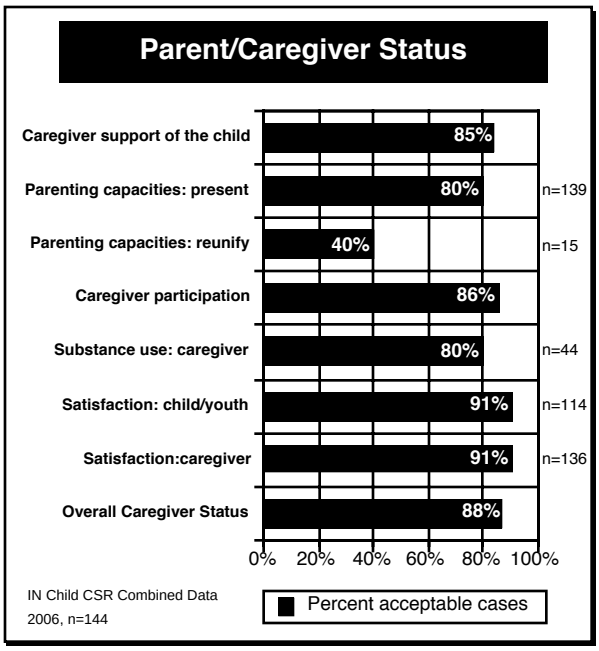
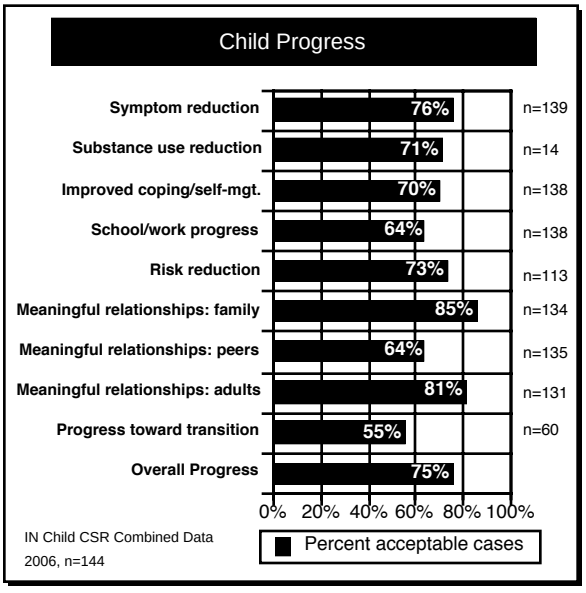


Display 26



Display 27



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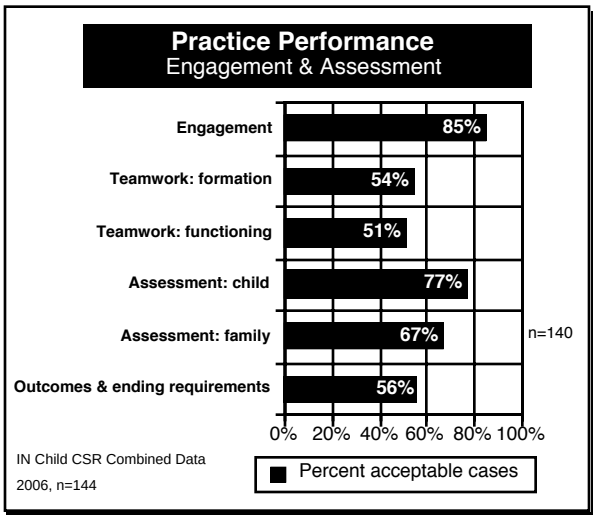

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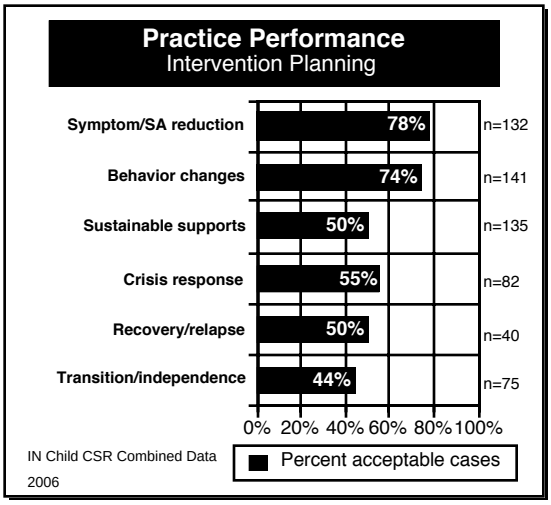
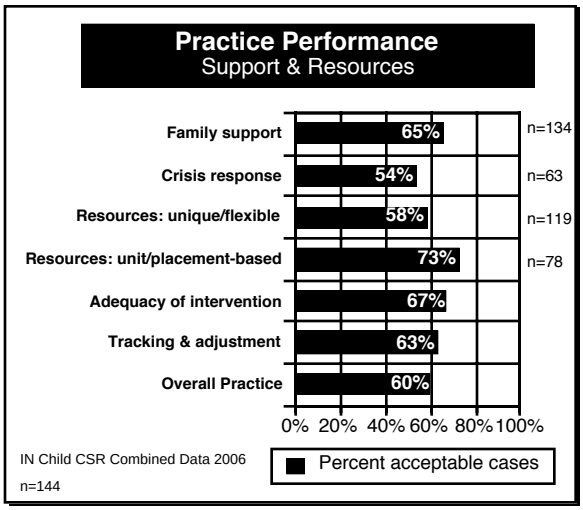


Display 30



Display 31

Child Case Review Outcome Categories

Status of Child/Family in Individual Cases

Outcome 2: Poor status for child/family, ongoing services minimally acceptable but limited in reach or efficacy. **4% (6 cases)**	**Outcome 1:** Good status for child/family, ongoing services acceptable. **56% (81 cases)**
Outcome 4: Poor status for child/family, ongoing services unacceptable. **17% (25 cases)**	**Outcome 3:** Good status for child/family, ongoing services mixed or unacceptable. **22% (32 cases)**
Unfavorable Child Status **21%**	Favorable Child Status **78%**

Acceptable System Performance **60%**

Acceptability of Service System Performance in Individual Cases

Unacceptable System Performance **39%**

IN Child CSR Combined Data 2006

n=144

CMHC had not performed with consistent diligence.

Display 32, presented on the next page, shows the overall ratings for child status, caregiver status, overall progress, and the overall ratings for practice performance for children in the SOC compared to children not in the SOC. Overall, there are higher ratings on the overall ratings, except for child progress and overall parent caregiver status. As can be seen, the ratings on most domains of practice performance are higher for children who are receiving services through a System of Care. **Display 33** compares the distribution of ratings from 1-6 between SOC and non-SOC children for practice performance. The quality and consistency of services is rated higher for children receiving services from an SOC model.

Display 34 provides the overall ratings in each category of domains for three age groups. As can be seen, the child status and system practice performance are better for the 5-9 age group than for the older groups and the 10-13 age group appears to be the most challenging to the system.

Display 35 provides the overall ratings for each category of domains for the three breakouts on level of functioning. The level of functioning was determined by using a modified child global assessment of functioning scale completed by the reviewers. The children with serious problems of functioning in multiple life areas are clearly the most challenging to the system and most likely are the ones who are in need of services provided with the most diligence, according to System of Care Principles.

The data from the child reviews show that there is considerable variability in the consistent delivery of services in accordance with a child's needs and in accordance with the Practice Principles of System of Care. The involvement of many of these children in other child-serving agencies adds complexity to the challenges of serving the high need children and increases the need for the multiple child-serving agencies to collaborate and communicate intensely to achieve the most successful outcome. When this collaboration and communication does occur, it improves the likelihood of achieving functional outcomes for children and families.

As with adults, the sampling process does not provide information about the timeliness and access to services.

Stakeholder Interviews

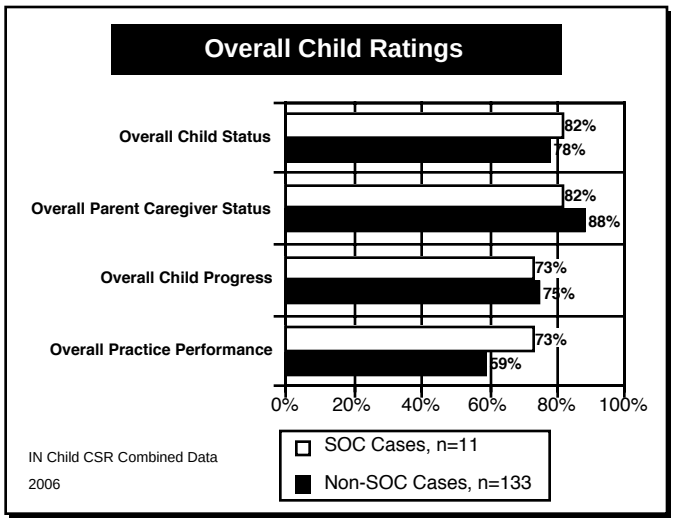
Over 250 persons participated in the stakeholder interviews. **Display 36** shows the various stakeholder groups that were included for adults and **Display 37** shows those included for children. Focus group meetings with the stakeholders were not able to include every group or CMHC in every region. Some CMHC staffs were always participants, as were probation and parole for both adults and children. Child welfare participated in all regions. NAMI participated in most regions and judges participated in a couple of regions. Because the regions of review were so large and frequently contained five to six community mental health centers, not all focus groups contained persons familiar with all areas of the region. Overall, attendance was good and participants were forthcoming and responsive to questions.

Because there is considerable redundancy between the stakeholder input and the themes identified through the CSR review and debriefing process, the input from stakeholders will be presented as part of the overall findings.

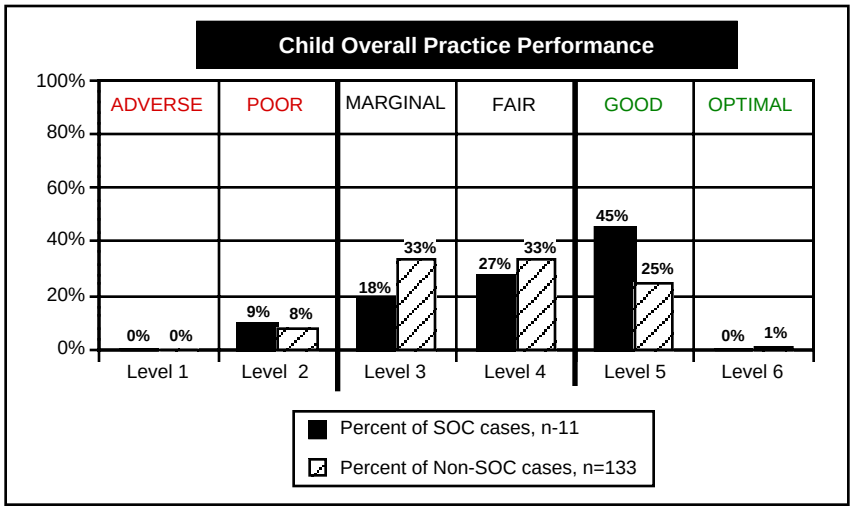
Overall Findings and Discussion

The results and findings presented here are based on the analysis of the CSR review ratings; the debriefing of CSR reviews, including the observations of the reviewers; the aggregate data analysis; and the input received from stakeholder focus groups. Because the baseline reviews were organized by large geographic regions, it is not possible to pinpoint the results by community mental health center. The results do show that there is variability and lack of consistency both across regions and CMHCs. However, the sampling process for both CSRs and focus groups do not allow

Display 32

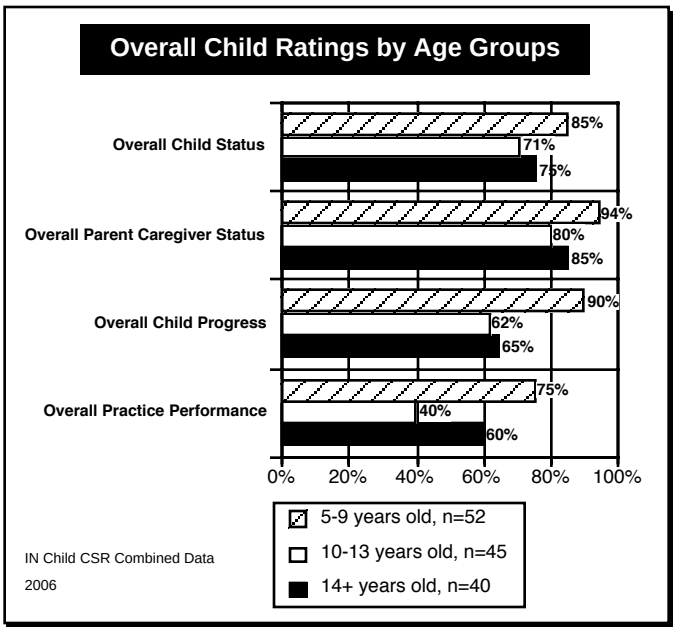


Display 33

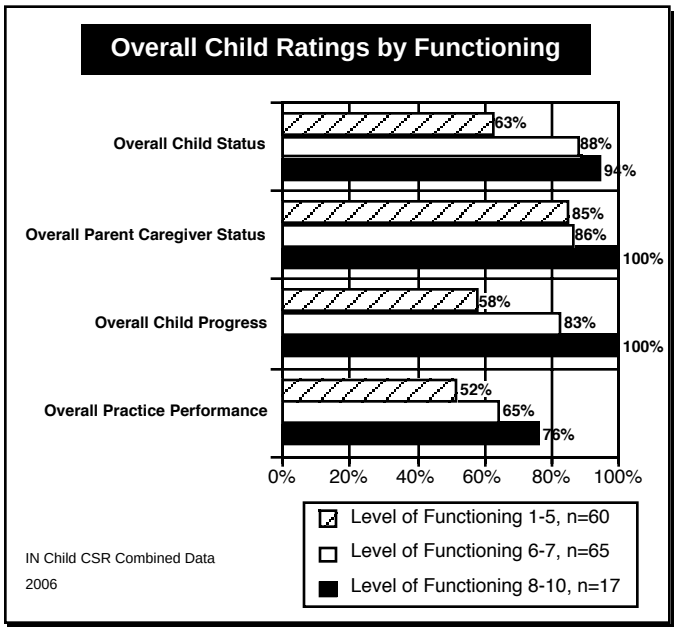


IN Child CSR Reviews 2006

Display 34



Display 35



Display 36

Adult Stakeholder Groups

Judges
Law Enforcement
Adult Probation
National Alliance for the Mentally Ill
Consumers of Services
Case Managers
Supervisors
Chief Executive Officers

Display 37

Child & Youth Stakeholder Groups

Juvenile Probation Staff
Child Welfare Caseworkers
Child Welfare Supervisors
Educators
Family Court Judges
Case Managers
Therapists
Supervisors

for specific analysis by CMHC.

The results show that there is an overall mental health system that generally meets the basic needs of persons who access the system. There are considerable strengths within the system. The reviews did not find major gaps in basic care or persons obviously falling through the cracks, as has been found in reviews conducted in other states. There is a reasonably adequate infrastructure in place and facilities and programs are distributed across the state. The strengths include:

1. When a person enters the mental health system, he/she will get basic services, such as evaluation, medication management, counseling, and case management/community support services, on a reasonably consistent basis. At a minimum, goals are set for maintenance and management of persons with serious mental illness.

2. Even though permanent housing is in short supply in some areas, CMHCs have generally developed some housing capacity, and while there are periods of time when persons may have to wait to get into housing, their housing needs are generally able to be met in a reasonably appropriate manner. These reviews did not identify concentrations of mentally ill persons living in marginal room and board arrangements as have been found in many states.

3. Persons in need of acute care are generally able to access short-term stabilization, however, it was frequently reported that access to longer-term inpatient psychiatric care was extremely limited. Medical detoxification is limited and most detoxification is done on an intensive outpatient basis. It should be noted, however, that there were considerable concerns expressed by community child-serving agencies other than mental health about the access to mental health services for children and the timeliness and responsiveness of services when initial access was achieved. Access to long-term inpatient beds, such as those at the state hospital, was reported to be very difficult and some persons thought there was more need for longer-term inpatient beds.

4. There were very positive and strong examples of high quality practice provided in some areas, including System of Care/wraparound services, ACT services, Clubhouse programs, school-based services, intensive in-home services, work development programs, and supported housing models. These quality programs are not provided consistently in all areas of the state.

5. There were also initiatives in development of Crises Intervention Teams (CITs) with law enforcement led by NAMI.

6. Some community mental health centers were implementing evidence-based practices, such as ACT, Integrated Dual Diagnosis Treatment (IDDT), wraparound services, and Dialectical Behavior Therapy (DBT).

7. The input of stakeholders in some areas regarding a specific CMHC's communication, collaboration, responsiveness, and performance was very consistent and positive. Sometimes, this was true for the work of a CMHC in some counties but not all of the counties they serve.

Overall, these findings support the fact that there are strengths in Indiana's system for the delivery of mental health and substance abuse services. The next portion of this report will address the findings indicating variability in the quality and consistency of performance and the extent to which services are provided in accordance with the Recovery Model for adults with mental illness and in accordance with the System of Care Principles for children.

There were a number of challenges and barriers identified that impede or hinder the timely and consistent delivery of services in accordance with the Principles of Recovery for adults and the Principles of System of Care for children.

Adult Recovery

There is progress towards the refinement of services to operate in accordance with the Principles of the Consumer Recovery Model, but awareness and understanding of frontline practitioners is still limited and variable. Some centers were working to implement services more consistently in accordance with the model. Other centers reported that the lack of match between what Medicaid will reimburse or concern for what they will reimburse in the future limits their implementation efforts.

Key components of the Principles of Consumer Recovery address treatment teams composed of persons working with the consumers and those persons identified by the consumers. These teams work with the consumers to develop the consumers' individual recovery plans that address steps and goals that will assist the consumers to have more full and integrated lives. These plans frequently address development of more social connections, entry to full-time or part-time work, achievement of permanent housing, or other goals as determined by the consumers.

The results of the CSR reviews for adults show that for the status of adults in the domains of social network and connection, education and career prep, work, and recovery activities are the lowest percentages of status ratings. For the domains assessing progress, the ratings are highest for reduction of psychiatric symptoms and substance use impairment. The lowest ratings of progress are for achieving recovery goals, education and work progress, and social integration. For system performance, personal recovery goals and planning were rated acceptable less than 50% of the time, as were efforts at social integration and planning adequately for transitions. Intervention adequacy, community integration efforts, and recovery plan adjustment were only rated acceptable 65% of the time.

Like the case review data, the focus groups reflected considerable variability of perspective regarding the quality and consistency of services across regions. For adult mental health, the most common themes were as follows.

1. Timely access to psychiatrists for evaluation and ongoing services was consistently reported as a barrier to timely and appropriate services. However, it should be noted that consumers and reviewers were quite positive about the work of psychiatrists when they were able to work with the consumers. High turnover of frontline staff was frequently reported as a problem that created discontinuity of services for the individuals being served.

2. Where Clubhouses were developed, there was not consistent fidelity to the Clubhouse model in all instances. It should be noted that the clubhouse in Ft. Wayne was a notable example of positive implementation, in accordance with the model, and they reported positive results in the areas of social integration and work were being achieved.

3. In general, services were perceived as being more client management and maintenance oriented than recovery oriented. Teams tended to be more of the traditional treatment team composition that staff cases on a periodic basis rather than consumer-determined individualized teams that are proactive and creative to assist persons to achieve their own personal recovery goals.

4. Concerns were expressed that the criteria for ACT admission were limiting and punished the centers who did the best job of achieving stability in the community for high need persons with serious mental illness. They recommended that the criteria and funding for ACT and other programs be examined and aligned so that CMHCs who keep clients in the community and out of more restrictive settings were not penalized and that clients had access to the level of services necessary to maintain them in a stable manner in the community.

5. It was acknowledged that demand for some services exceeded capacity and that some delays in access and delivery of services were necessary to try to manage demand beyond the current capacity.

6. There is not good understanding nor consistent expectations of what service capacities must exist in all areas of the state to have a full service array. There is not a database that tracks capacity across all areas of the state for adults or for children. The state should consider developing the ability to track existing capacity in all areas of the state.

7. There was great variability in the amount of collaboration and partnering that occurs with the local court, probation and parole, and vocational rehabilitation. In some areas, there are strong collaborative programs, such as drug court, jail screening and diversion, and consistent communication with parole. These are more the exceptions than the rule, and in some areas, the input was that the CMHC was only used as a last resort or when they had to, such as access to state hospital inpatient beds. The most frequent concern expressed by adult probation was that they were not consistently informed about clients who were not participating in treatment or who had other changes in status or context.

8. There is a reasonably high probability that a person with serious mental illness seeking services from the public mental health system will be able to access basic medication, case management, and counseling services, though there may be some delays. When persons are involved with other agencies, such as court or probation, there is more variability in the degree of collaboration, communication, and partnership between the parties involved. More efforts need to be made to increase the achievement of recovery goals, such as social connection and integration and work.

Children—Principles of System of Care

The CSR data and the stakeholder input show more variability and lack of consistency of performance in serving children with mental health problems than for adults. There were very positive examples of System of Care implementation in some areas. There were excellent examples of school-based programs and collaboration with DCS child welfare programs and with juvenile probation and family courts, including some that occurred through contractual arrangements. There were also examples where the child-serving agencies chose to not use the CMHC and accessed services either from other child-serving organizations or a more distant CMHC.

The Principles of System of Care provide a practice model and guidelines for how therapeutic interventions should be provided to children with emotional and behavioral disorders. The premise is that all services and interventions should be based on a carefully developed understanding of the child and family. The understanding is achieved by working with the family as partners and collaborators in developing an individualized plan of intervention based on the assessment of the child and, in some cases, other family members and in consideration of the families' preferences and capacities. When children are involved in other child-serving agencies, such as education, child welfare, and juvenile justice, then it is expected that persons who work with the children in those settings will participate in planning and coordination in order to maximize the effort of all persons working with the children. The goal of System of Care is to keep children in their homes and in school learning to the maximum extent possible.

The CSR reviews examined whether children were being served in accordance with the principles and the near-term results that were being achieved. As presented above, the CSR reviews showed that the highest rated child system performance domains are child and family engagement, assessment of the child, symptom reduction, and behavioral change. The lowest rated areas are in the domains of team functioning, functional outcomes, and planning focus and goals addressing what is necessary to assist the child and family to be able to function more independently with the supports in place necessary to support the child to maintain progress. Essentially, the plans are focused on near-term symptom reduction and behavior management and less on what it will take to develop and sustain improved functioning at

home, in school, and in the community. As a result of these weaknesses, overall practice performance was rated acceptable only 60% of the time.

There were excellent examples of children being served in school-based programs; with evidence-based practices, such as DBT; by wraparound services and System of Care teams; and with in-home services. The challenge is that there is wide variability in performance across counties and CMHCs.

The stakeholders identified specific examples of the factors that contribute to the variability and quality of services across the state. Some of the issues identified included:

- High turnover of therapists
- Access to psychiatrists on a timely basis
- Non-responsiveness to timeliness and communication issues
- Insufficient communication between child-serving partners and lack of participation
- Weak individual child team functioning, including lack of participation by various child-serving agencies
- Highly variable quality of skills provided by persons providing therapeutic interventions
- Lack of understanding of the mandates and timelines that have to be met when a child is involved with the legal system.

In nearly all counties in which a System of Care was functioning, stakeholders reported greater satisfaction with the access to services and the results being achieved. This is consistent with the CSR ratings of children in the System of Care compared to children who were not in the System of Care.

The child CSR protocol included data on the services that were being provided to children and the services that were needed and not provided. **Display 38**, shown on the next page, shows the services provided and received for both the child and the family. The data show that services, such as family counseling, intensive in-home supports, life skills training, mentoring/one-on-one and independent living training, were needed but not provided. For the family/caregivers, the services identified as needed but not provided were parent training and support, therapeutic counseling for the family, substance abuse and domestic violence counseling, therapeutic counseling for the parent, in-home supports, and respite services. These data show how the services breakdown for the specific children and families in the sample and what services were needed in order to serve the families with the intensity and scope of services necessary to improve the likelihood of achieving successful outcomes.

In summary, the availability, access, and timeliness of mental health services for children varies widely across counties. Where System of Care is operational, there is better interagency coordination, communication, and satisfaction with the results achieved. There are excellent school-based programs and collaboration with child welfare and juvenile courts and some areas with very poor communication and collaboration. More work needs to be done across child-serving agencies at both the state and local level to increase the level of coordination and ensure that services are well coordinated, timely, and not redundant across child-serving agencies.

Summary and Suggestions

Displays 39 and **40** show the comparison of status ratings and practice performance ratings across regions for adults and children. The data show that practice performance was rated as acceptable for adults more often than for children. The data show that there is variability across regions, but it should be noted that there were excellent examples of high quality and consistent services in all regions and areas of weakness in all regions.

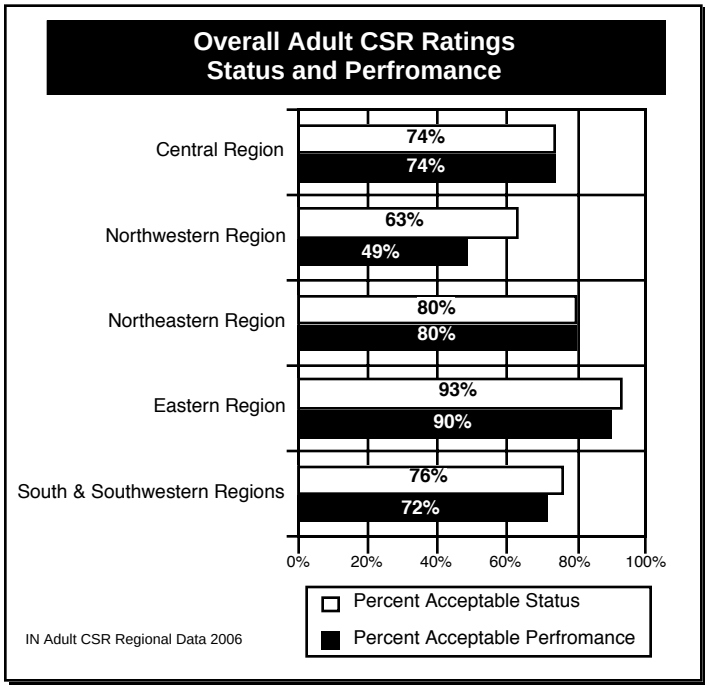
The quality and consistency of services is determined by whether frontline practitioners have the knowledge/skills, a manageable workload, a clear understanding of what the practice expectations are, and the feedback mechanisms to give them feedback about whether they are actually practicing in accordance with expectations. Currently, staff do not have a clear and consistent understanding of what the real practice expectations are

Display 38

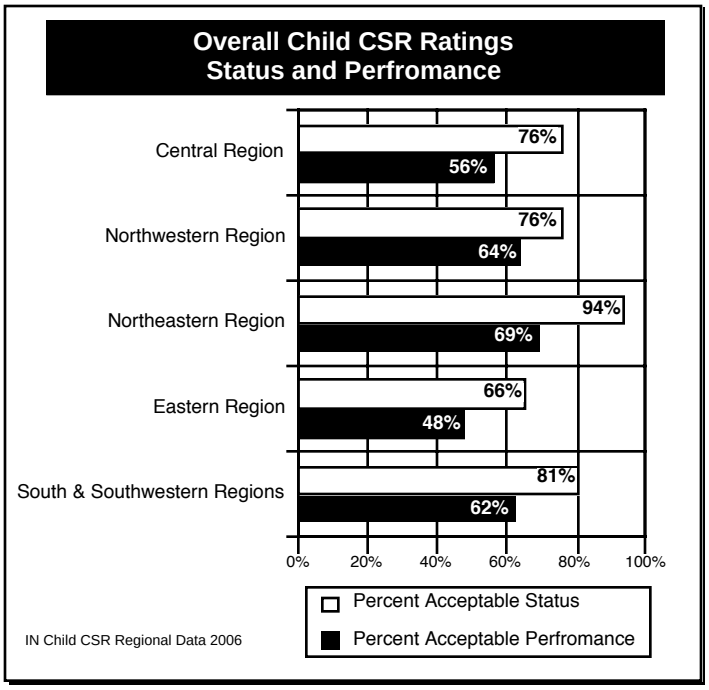
Child Service Data

Type of Service		Child/Youth				Family/Caregiver			
		Received		Needed		Received		Needed	
Early intervention services (0-5)	1.	21	15%	6	4%	3	2%	3	2%
Foster care	2.	24	17%	3	2%	1	1%		0%
Diagnosis and assessment	3.	121	85%	8	6%	24	17%	8	6%
Service planning	4.	109	76%	6	4%	29	20%	5	3%
Consultation	5.	57	40%	2	1%	12	8%	3	2%
Special education instruction	6.	70	49%	13	9%	3	2%	1	1%
Homebound services	7.	19	13%	1	1%	6	4%	2	1%
Alternative education services	8.	17	12%	3	2%	1	1%		0%
Transition services	9.	9	6%	11	8%	3	2%	1	1%
Teen mom/parent	10.	1	1%	1	1%	1	1%		0%
Life skills training	11.	25	17%	15	10%	4	3%	4	3%
Independent living training	12.	5	3%	11	8%	1	1%	1	1%
Vocational training/placement	13.	2	1%	8	6%		0%	5	3%
Substance abuse treatment	14.	5	3%	2	1%	8	6%	6	4%
Domestic violence	15.	1	1%	2	1%	2	1%	8	6%
Sexual abuse/offender	16.	10	7%	7	5%	3	2%	1	1%
Functional behavioral awareness	17.	27	19%	7	5%	4	3%	5	3%
Academic counseling	18.	24	17%	8	6%		0%	1	1%
Therapeutic counseling: child	19.	121	85%	4	3%	2	1%		0%
Therapeutic counseling: parent	20.	15	10%		0%	57	40%	23	16%
Therapeutic counseling: family	21.	55	38%	19	13%	49	34%	29	20%
Day treatment program (MH)	22.	23	16%	4	3%		0%	2	1%
Residential treatment program	23.	8	6%		0%	1	1%		0%
Crisis stabilization services	24.	28	20%	3	2%	7	5%	2	1%
Inpatient hospitalization	25.	26	18%		0%	1	1%		0%
Medication management services	26.	97	68%	9	6%	9	6%	4	3%
Parent training and support	27.	20	14%	2	1%	62	43%	30	21%
Daycare/child care	28.	6	4%	3	2%	1	1%	7	5%
Transportation	29.	29	20%	3	2%	6	4%	4	3%
Respite care services	30.	4	3%	5	3%	1	1%	18	13%
Family preservation	31.	11	8%	2	1%	5	3%	7	5%
In-home supports	32.	44	31%	11	8%	31	22%	21	15%
Emergency shelter services	33.		0%	1	1%	2	1%	1	1%
DJO/court supervision	34.	6	4%	1	1%	3	2%		0%
Probation/Suspension	35.	14	10%	1	1%	2	1%		0%
High risk intervention	36.	5	3%	2	1%		0%	2	1%
Case management	37.	111	78%	11	8%	36	25%	7	5%
Therapeutic home/Tx foster home	38.	9	6%	3	2%		0%		0%
Intensive (wraparound) support	39.	20	14%	12	8%	7	5%	11	8%
Mentor/one-to-one services	40.	14	10%	21	15%	1	1%	2	1%
Advocacy services	41.	14	10%	9	6%	5	3%	10	7%
Other:	42.	10	7%	6	4%	1	1%	1	1%
Other:	43.	4	3%	2	1%		0%		0%

Display 39



Display 40



for the consistent implementation of System of Care Principles for children and Recovery Principles for adults. Local areas pick and choose what particular evidence-based practice they want to develop or how willing they are to work with partner agencies. The leadership and staff have questions as to whether the business model/ reimbursement framework supports the program expectations that are being espoused. They are not sure that Medicaid and the Mental Health Division expectations are aligned. However, it should be noted that there was considerable variability in the performance data and there was clearly more commitment in some CMHCs to the practice models. Where there was clear commitment to implementation of System of Care and Recovery, the data trend was for higher rated system performance. The data suggest that given the current funding and requirements when there is commitment by management to the practice principles, the practice models were more likely to be implemented.

Currently, there is not a fully developed framework and capacity to measure both quantitatively and qualitatively the outcomes being achieved using a combination of key indicator quantitative data and CSR qualitative data. This capacity is currently being developed both for key quantitative indicators and through the baseline data for the CSR.

In order to continue to improve consistency and quality of services, it is critical that the measurement capacity be brought to full development and that the ambiguities and concerns regarding the business model supporting the program model be resolved. These two accomplishments would allow and support much greater attention to the development of high quality practice and consistency across the state.

It is recommended that future CSR reviews be done at the CMHC-specific level and that they combine the CSR quality review with the quantitative key indicator data and analysis. These reviews would include a service array analysis, a quantitative profile using process and key indicator data, as well as stakeholder focus groups and CSR reviews. The focus of the reviews would be to define clearly the current capacities and consistency of practice in each CMHC so that capacity and practice development next steps could be developed.

Appendix A:
Questions Posed in the
Consumer Services Review Protocols

Consumer Services Review
For an Adult Service Participant

Questions to be Answered

Initial Field Use Version

Developed for

The Indiana Family and Social Services Administration,
Division of Mental Health and Addiction

by
Human Systems and Outcomes, Inc.

May 2006

INTRODUCTION TO THE CONSUMER SERVICE REVIEW PROTOCOL

UNDERSTANDING PRACTICE AND RESULTS

The Consumer Service Review (CSR) uses an in-depth case review method. It applies a performance appraisal process to find out how participants are benefiting from services received and how well local services are working for a sample of participants at a point in time. Each person served is a unique "test" of the service system. Small representative groups of service participants are reviewed to determine their current status and related system performance results.

Questions about how an adult service participant is doing include:

- Is the person safe from manageable risks of harm caused by others or by him/herself? Is he/she free from abuse/neglect?
- Does the person have adequate living arrangements and income to cover basic living requirements?
- Are the person's basic physical and health needs met?
- Does the person have the opportunity to pursue personal goals and aspirations in rehabilitation, recovery, education, and career?
- Is the person connected to a natural support network of friends, family, and peers?
- Is the person making progress in symptom management, recovery, and personal goals?

Positive answers to these questions show that persons served by local staff and service providers are doing well. When negative patterns are found, improvements can and should be made to strengthen frontline practice, working conditions, and services.

Questions about how well the service system is working include:

- Does the person, clinicians, supporters, and service providers share a "big picture" understanding of the person's situation, needs, strengths, preferences, and goals so that sensible supports and services can be provided?
- Do the "service partners" know and understand the personal recovery goals and how to use services to enable the person to achieve his/her therapeutic and personal recovery goals?
- Does the person have an individualized service plan that organizes treatment strategies, supports, and services to be provided, spans all involved service providers, and is responsive to the person's directions, preferences, and goals?
- Are services and service approaches integrated across providers and settings to achieve positive results for the person?
- Are family members or significant others getting the information and assistance necessary for them to be effective supports while allowing the person to pursue his/her personal and recovery goals?
- Are the person's services being coordinated effectively across settings, providers, and agencies?
- Are the supports and services provided reducing risks and improving daily functioning? Are needed emergency services provided on a timely, competent, and respectful basis?
- Are services and results tracked frequently with services modified to reflect changing needs and life circumstances? Are services effective in improving well-being and functioning while reducing risks of harm, restriction, or decompensation?

The CSR provides a close-up way of seeing how individual participants are doing in the areas that matter most. It provides a penetrating view of practice and what is contributing to results.

WHAT'S LEARNED THROUGH THE CSR

The CSR involves case reviews, observations, and interviews with the person and people important to the person. Results provide a rich array of learnings for next-step action and improvement. These include:

- Detailed stories of practice and results in real situations and recurrent patterns observed across persons reviewed.
- Deep understandings of contextual factors that are affecting daily frontline practice in a site or agency being reviewed.
- Quantitative patterns of consumer status and practice performance results, based on key measures.
- Noteworthy accomplishments and success stories.
- Emerging problems, issues, and challenges in current practice situations explained in local context.
- Critical learning and input for next-step actions and for improving program design, practice, and working conditions.
- Repeated measures revealing the degree to which important service system transformation aspirations are being being fulfulled in daily frontline recovery-oriented practice for adult consumers of mental health and addiction services.

CSR Interpretative Guide for Consumer Status

Maintenance Zone: 5-6

Status is favorable. Efforts should be made to maintain and build upon a positive situation.

6 = **OPTIMAL STATUS**. The best or most favorable status presently attainable for this person in this area [taking age and ability into account]. The person doing great! Confidence is high that long-term goals or expectations will be met in this area.

5 = **GOOD STATUS**. Substantially and dependably positive status for the person in this area with an ongoing positive pattern. This status level is consistent with attainment of long-term goals in area. Status is "looking good" and likely to continue.

Acceptable Range: 4-6

Refinement Zone: 3-4

Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.

4 = **FAIR STATUS**. Status is minimally or temporarily sufficient for the person to meet short-term objectives in this area. Status is minimally acceptable at this point in time, but may be short-term due to changing circumstance, requiring change soon.

3 = **MARGINAL STATUS**. Status is marginal or mixed and not quite sufficient to meet the person's short-term objectives now in this area. Status now is not quite enough for the person to be satisfactory today or successful in the near-term. Risks are minimal.

Improvement Zone: 1-2

Status is now problematic or risky. Quick action should be taken to improve the situation.

2 = **POOR STATUS**. Status continues to be poor and unacceptable. The person seems to be "stuck" or "lost" and status is not improving. Risks are mild to moderate.

1 = **ADVERSE STATUS**. The person's status in this area is poor and getting worse. Risks of harm, restriction, separation, regression, and/or other poor outcomes are substantial and increasing.

Unacceptable Range: 1-3

CSR Interpretative Guide for Consumer Performance

Maint. - Green Zone: 5-6

Performance is effective. Efforts should be made to maintain and build upon a positive practice situation.

6 = **OPTIMAL PERFORMANCE**. Excellent, consistent, effective practice for this person in this function area. This level of performance is indicative of exemplary practice and results for the person. ["Optimum" does not imply "perfection."]

5 = **GOOD PERFORMANCE**. At this level, the system function is working dependably for this person, under changing conditions and over time. Effectiveness level is consistent with meeting long-term goals for the person. [Keep this going for good results]

Acceptable Range: 4-6

Refine. - Yellow Zone: 3-4

Performance is minimal or marginal and maybe changing. Further efforts are necessary to refine thepractice situation.

4 = **FAIR PERFORMANCE**. This level of performance is minimally or temporarily sufficient for the person to meet short-term objectives. Performance may be time-limited or require adjustment soon due to changing circumstances.[Some refinement is indicated]

3 = **MARGINAL PERFORMANCE**. Practice at this level may be under-powered, inconsistent, or not well-matched to need. Performance is insufficient for the person to meet short-term objectives. [With refinement, this could become acceptable in the near future.]

Improve. - Red Zone: 1-2

Performance is inadequate. Quick action should be taken to improve practice now.

2 = **POOR PERFORMANCE**. Practice at this level is fragmented, inconsistent, lacking in intensity, or off-target. Elements of practice may be noted, but it is incomplete/not operative on a consistent basis.

1 = **ADVERSE PERFORMANCE**. Practice may be absent or not operative. Performance may be missing (not done). - OR - Practice strategies, if occurring in this area, may be contra-indicated or may be performed inappropriately or harmfully.

Unacceptable Range: 1-3

OUTLINE OF THE CONSUMER SERVICE REVIEW PROTOCOL

TABLE OF CONTENTS

Listed below is the table of contents for this CSR protocol. In addition to these materials, reviewers are provided a set of additional working papers that are used for reference and job aids used for particular tasks conducted during the review.

Protocol Sections and Areas

Consumer Service Review Status Indicators

Person Status Indicators

Presented below is the set of status indicators contained in the CSR Protocol version being used by the **Design Team**. These indicators represent common sense questions used to determine the current status of the person.

Persons using this list of questions are directed to the **CSR Protocol** for further explanation of these questions and matters to consider when applying these questions to a person receiving supports and services. Training, certification, and supervision are required for persons conducting case review activities using any version of a CSR Protocol and related review process. Status is determined for the most recent 30-day period. The CSR person status indicators follow:

Community Living

1. **SAFETY:** • Is this person safe from manageable risks of imminent harm in his/her daily settings and activities? • Is this person verbally hostile to others which may provoke a physically aggressive? • Is this person aggressive toward others? • Does the person endanger him/herself?

2. **INCOME & CONTROL:** To what degree: • Are the person's earned income and economic supports adequate to cover basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, leisure, child care)? • Is this person accessing, receiving, and controlling the economic benefits to which he/she is entitled? • Does the person have economic security sufficient for maintaining stability and for effective future life planning?

3. **LIVING ARRANGEMENTS:** • Is this person living in a home that he/she chose, with supports that are necessary and sufficient for safe and successful pursuit of recovery? • If not, is this person residing in a community living arrangement that is necessary to meet the person's therapeutic and recovery needs? • Are the person's culture, language, and living and housemate preferences addressed in an appropriate and supportive manner, consistent with his/her recovery goals?

4. **SOCIAL NETWORK:** To what degree: • Is this person connected to a support network of family, friends, and peers, consistent with his/her choices and preferences? • Is this person provided access to peer support and community activities? • Does this person have opportunities to meet people outside of the service provider organization and to spend time with them? • Does the social network support recovery efforts?

5. **SATISFACTION WITH SERVICES:** To what extent is the person satisfied with the treatment, support services, respect, and recovery progress that he/she is presently experiencing?

Physical/Emotional Status

6. **HEALTH/PHYSICAL WELL-BEING:** • Is this person in the best attainable health*? • Are the person's basic physical needs being met? • Does the person have access to and benefit from health care services, as needed?

7. **SUBSTANCE USE:** • To what degree is the person free from substance use impairment? • If the person is in recovery from a substance use disorder, is the living arrangement atmosphere supportive of recovery efforts?

8. **MENTAL HEALTH STATUS:** • Is the adult's mental health status currently adequate or improving? • If symptoms of mental illness are present, does the adult have access to mental health care, necessary and sufficient, to reduce symptoms and improve daily functioning?

Meaningful Life Activities

9. **VOICE & ROLE IN DECISIONS:** To what degree: • Is this person actively engaged in service decisions? • Does participation enable the person to express to the service team: (1) preferences about where and with whom to live and where to work, (2) choice of daily routines, (3) wishes about how to spend his/her time and money, (4) choice of service providers, and (5) satisfaction/dissatisfaction with services? • If the person is resistant to participation, are reasonable efforts being made to engage him/her and to support his/her participation?

10. **EDUCATION/CAREER DEVELOPMENT**: • Is this person actively engaged in educational activities (e.g., adult basic education, GED course work, or post-secondary education) vocational training programs, or transitional employment? • Is the person receiving information about work benefits, access to work supports, rights, responsibilities, and advocacy? • If not, does this person have access to such opportunities, subject to the person's needs and preferences?

11. **WORK:** • Is this person actively engaged in employment, competitive or supported (earning federal minimum wage or above, in an integrated community setting) or in an individual placement with supports in a productive situation? If not, does the person have access to productive opportunities (e.g. consumer- operated services, an internationally accredited clubhouse, community center or library)?

12. **RECOVERY ACTIVITIES:** • To what degree is this person actively engaged in activities necessary to improve capabilities, competencies, coping, self-management, social integration, and recovery? • If not engaged in recovery, does this person have access to recovery and relapse prevention opportunities, subject to his/her needs, life ambitions, and personal preferences?

13. **OVERALL STATUS OF THE PERSON:** • Based on the review findings determined for Status Reviews 1–12 above, how well is

CONSUMER SERVICE REVIEW PROGRESS & PRACTICE INDICATORS

this person presently doing? [Person's overall status is considered acceptable when specified combinations and levels of review findings are present.]

PERSON'S PROGRESS

Presented below is a set of questions used to determine the progress of a person receiving services. A primary focus is placed on the pattern of changes recently occurring for the participant. Progress should be associated with treatment goals and services provided to the person.

1. **SYMPTOM MANAGEMENT:** To what extent are troublesome symptoms of mental illness being reduced, coped with, and personally managed by this individual?

2. **REDUCTION OF SUBSTANCE ABUSE:** To what extent is the person making progress in reducing substance use and related impairments, while achieving sobriety, relapse prevention, and improved self-management of life choices that promote recovery?

3. **IMPROVED PERSONAL RESPONSIBILITIES:** To what extent is the person making progress in key life areas, including relapse prevention and self-management in the community, where appropriate?

4. **EDUCATION/WORK PROGRESS:** To what extent is this person presently making progress toward educational course completion - OR - making progress toward getting and keeping a job?

5. **PROGRESS TOWARD PERSONAL RECOVERY GOALS:** To what degree is the person making progress toward attainment of personally selected recovery goals that may be stated in his/her recovery plan?

6. **RISK REDUCTION:** To what extent is reduction of risks of harm, self-endangerment, use of chemical substances, and/or utilization of coercive techniques being accomplished with and for this person?

7. **SUCCESSFUL LIFE ADJUSTMENTS:** Consistent with this person's needs and goals, to what extent is the person making successful transitions and life adjustments between living settings, service providers, levels of care, and from dependency to personal control and direction?

8. **IMPROVEMENT IN SOCIAL INTEGRATION:** • To what degree is this person increasing his/her social connections among a variety of social groups in the community, consistent with the person's recovery goals? • Does the person access services and participate in social group activities available to all citizens? • Does this person affiliate with community groups (secular or sacred), with special accommodations and supports, consistent with the person's desires? • Is the person benefiting from increased social integration in the community?

9. **IMPROVED MEANINGFUL PERSONAL RELATIONSHIPS:** To what degree is the person improving meaningful personal relationships with peers, friends, and family members, consistent with the person's preferences?

10. **OVERALL PROGRESS PATTERN:** Taking into account the relative degree of progress observed for the person on the above eight progress indicators, what is the overall pattern of progress made by this person: optimal, good, fair, marginal, poor, or adverse? Overall progress is considered acceptable when the overall pattern is deemed to be fair or better.

PRACTICE PERFORMANCE

Presented below is a set of questions used to determine the performance of practice (essential system functions) for the person in a review. These questions focus on treatment and support functions rather than formal service system procedures.

Planning Treatment & Support

1. **ENGAGEMENT**: • How well are interveners developing and maintaining a mutually beneficial partnership with the person that is sustaining his/her interest in and commitment to an intervention-driven recovery process? • To what extent have interveners taken action to form a trust-based working relationship with the person that is supporting practice functions necessary for recovery? • Are interveners open, receptive, and willing to make accommodations to increase the person's engagement and level of participation in recovery planning and work?

2. **TEAMWORK:** • TEAM FORMATION: To what degree: (1) Have the "right people" for this person formed a working team that meets, talks, and plans together? (2) Does the team have the skills, knowledge of this person, and abilities necessary to organize effective services for this person, given his/her level of complexity and cultural background? • TEAM FUNCTIONING: To what degree: (1) Do members of the team collectively function as a unified team in planning services and evaluating results? (2) Do actions of the team reflect a coherent pattern of effective teamwork and collaborative problem solving that supports this person's recovery goals?

3. **ASSESSMENT & UNDERSTANDING:** To what degree: • Does the service team have a working understanding of the person's strengths and needs in the context of the person's recovery goals as well as underlying issues that must change for the person to have a safe and satisfying life and to fulfill desired adult roles? • Does the team understand the person's aspirations for personal power and control in his/her life? • Are diagnoses used for the person's treatment consistent with current understandings among providers? • Is the relationship between the diagnoses and the person's bio/psycho/social functioning in daily activities well understood? • Are any co-occurring conditions identified, including substance abuse?

CONSUMER SERVICE REVIEW PRACTICE INDICATORS

4. **PERSONAL RECOVERY GOALS (PRGs):** To what degree: • Are there PRGs reflecting the person's life and career aspirations? • Do PRGs focus and guide the recovery/treatment process for this person?• If met, will these goals lead to the person managing successfully in daily settings, with supports and services as necessary, to achieve ongoing recovery?

5. **RECOVERY PLANNING:** • To what degree is person-centered, team-driven, ongoing, recovery-focused planning used for selecting and organizing intervention strategies, actions, resources, and schedules to drive intervention processes forward to help meet the person's recovery goals?

Providing Treatment & Support

6. **RESOURCES:** • Are the resources (both informal and formal) necessary to action the strategies selected to meet the person's recovery goals available for use by the person, interveners, and service team? • Is access and use of these resources of sufficient quality, quantity, duration, and intensity to meet the person's recovery goals on a timely basis? • Are any unavailable but necessary resources or supports identified by the team? • Are reasonable efforts being undertaken by the team to secure or develop any needed but unavailable supports, services, or resources?

7. **INTERVENTION ADEQUACY:** To what degree are the recovery-related interventions, actions, and resources provided to the person of sufficient power (precision, intensity, duration, fidelity, and consistency) required to produce results necessary to achieve the person's recovery goals?

8. **URGENT RESPONSE:** • Is there timely access to and provision of effective services to stabilize or resolve emergent or episodic problems, as needed by this person? • Are crisis services accessed and delivered in a manner that respects and does not demean the person?

9. **MEDICATION MANAGEMENT:** • Is the use of psychiatric/addiction control medications for this person necessary, safe, and effective? • Does the person have a voice in medication decisions and management? • Is the person routinely screened for medication side effects and treated when side effects are detected? • Have new atypical/current generation drugs been tried, used, and/or appropriately ruled out? • Is the use of medication coordinated with other treatment modalities and with any treatment for any co-occurring conditions (e.g., seizures, diabetes, asthma/COPD, HIV)?

10. **SECLUSION/RESTRAINT:** • If emergency seclusion or restraint has been used for this person, was each use: (1) Done only in an emergency? (2) Done after less restrictive alternatives were found insufficient or impractical? (3) Ordered by a trained, authorized person? (4) Accomplished with proper techniques that were safely and respectfully performed by qualified staff? (5) Effective in preventing harm? and (6) Properly supervised during use and evaluated afterwards?

Managing Treatment & Support

11. **SUPPORTS FOR INTEGRATION:** • Is the array of in-home and community-based supports provided to this person sufficient [in design, intensity, and dependability] to meet the person's preferences and assist him/her to achieve recovery goals? • Are supports effective during life change adjustments and in maintaining the person within the home, job, and community? • Where applicable, is individually assigned staff (job coach, respite/crisis worker, skills trainer) receiving the education and supports necessary to maintain an appropriate relationship and support arrangement for the person?

12. **SERVICE COORDINATION & CONTINUITY:** • Is there a single point of coordination, accountability, and continuity in the organization, delivery, and results of treatment, supports, and services for this person? • Are planned interventions and services well coordinated across providers, funding agencies, and service settings for this person, especially when entering and leaving intensive service settings?

13. **RECOVERY PLAN ADJUSTMENT:** • Is the service coordinator using monitoring activities to follow this person's progress, changing conditions, consistency and effectiveness of supports, and results achieved? • Does the service coordinator keep all providers informed and discuss recovery intervention fidelity, barriers encountered, and progress being made? • Are services adjusted in response to problems encountered, progress made, changing needs, and knowledge gained to create a process that supports recovery?

14. **CULTURALLY APPROPRIATE PRACTICE:** • Are any significant cultural issues for the person being identified and addressed in practice? • Are the behavioral health services provided being made culturally appropriate via special accommodations in the person's engagement, assessment, planning, and service delivery processes?

15. **OVERALL PRACTICE PERFORMANCE:** Based on the review findings determined for Service Reviews 1-14, how well is the service system functioning for this person now? [Overall practice performance is considered acceptable when specified combinations and levels of review findings are present. A special scoring rubric is used to determine Overall Practice Performance for a person in this review process.]

Consumer Services Review
For a Child and Family

A Reusable Guide for a Case-Based Review of Locally Coordinated Children's Services

List of Questions in the Field Use Version

Developed for

The Indiana Family and Social Services Administration,
Division of Mental Health and Addiction

by
Human Systems and Outcomes, Inc.

May 2006

OUTLINE OF THE CONSUMER SERVICE REVIEW PROTOCOL

TABLE OF CONTENTS

Listed below is the table of contents for this CSR protocol. In addition to these materials, reviewers are provided a set of additional working papers that are used for reference and job aids used for particular tasks conducted during the review.

Consumer Service Review Status Indicators

Child & Family Status Indicators

Presented below is the set of child & family status indicators contained in the CSR Protocol version being used by the **Design Team**. Many of these items were selected for inclusion because of their consistency with the **Child and Family Services Review** (CFSR). These indicators represent common sense questions used to determine the current status of the child.

Persons using this list of questions are directed to the **CSR Protocol** for further explanation of these questions and matters to consider when applying these questions to a child receiving supports and services. Training, certification, and supervision are required for persons conducting case review activities using any version of a CSR Protocol and related review process. Status is determined for the most recent 30-day period. The CSR child status indicators follow:

Child Status Indicators

1. **SAFETY:** • Is the child safe from injury caused by him/herself or others in his/her daily living, learning, and recreational environments? • Are others safe from the child? • Is the child free of abuse, neglect, and sexual exploitation in his/her place of residence?

2. **STABILITY:** To what degree are: (1) The child's daily living, learning, and work arrangements stable and free from risk of disruption? (2) The child's daily settings, routines, and relationships consistent? (3) Known risks being managed to achieve stability and reduce the probability of future disruption? (past six months)

3. **PERMANENCY:** • Is the child living with parents or out-of-home caregivers that the child, parents or out-of-home caregivers, and other stakeholders believe will keep lifelong? • If not, are permanency efforts presently being implemented on a timely basis that will ensure that the child soon will live in enduring relationships that provide a sense of family, stability, and belonging? (past 30 days)

4. **LIVING ARRANGEMENT:** • Is the child in the most appropriate living arrangement, consistent with the child's needs for family relationships, connections, age, ability, special needs, and peer group? • Is this living arrangement consistent with the child's language and culture? (past 30 days)

5. **PHYSICAL HEALTH STATUS:** To what degree: • Is the child achieving and maintaining his/her optimum health status? • If the child has a serious or chronic physical illness, is the child achieving his/her best attainable health status given the disease diagnosis and prognosis? (past 30 days)

6. **EMOTIONAL/BEHAVIORAL WELL-BEING:** • To what degree is the child symptom free of anxiety, mood, thought, or behavioral disorders that interfere with his/her capacity to participate in and benefit from his/her education? • What is the child's current level of functioning in his/her daily settings and activities?

7. **SUBSTANCE USE:** • Is the child free from substance use impairment? • If the child is in recovery from a substance use disorder, is the family home atmosphere supportive of recovery efforts?

8. **ACADEMIC STATUS:** Is the child [according to age and ability]: (A) in an appropriate educational placement; (B) regularly attending school; (C) actively engaged in instructional activities; (D) performing at grade level or IEP level in order to meet expectations for graduation and transition to employment?

9. **SOCIAL SUPPORTS:** • Consistent with age and ability, to what degree is the child: (1) Developing an age-appropriate and culturally-appropriate circle of positive friends/supporters? (2) Participating in social/recreational activities necessary for gaining important life experiences? (3) Gaining group affiliation, adult guidance, and social connections via ties to community organizations (faith-based or secular)? (4) Benefitting from a significant, enduring relationship with one or more adults who provide positive role modeling, support, and guidance?

10. **LAWFUL BEHAVIOR:** • Does the child/youth behave in legally responsible ways at school, at home, and/or in daily community settings (as appropriate to age and developmental level)? • If involved with the juvenile justice system, is the child/youth complying with the court plan, avoiding reoffending, and developing appropriate friendships and activity patterns?

OVERALL CHILD STATUS: • Based on the CSR findings determined for the Child Status Exams 1–10, how well is this child presently doing? Overall child status is considered

CONSUMER SERVICE REVIEW STATUS & PROGRESS INDICATORS

acceptable when specified combinations and levels of examination findings are present. A special scoring procedure is used to determine Overall Child Status using a six-point rating scale.

Parent/Caregiver Status Indicators

Parent/caregiver status is determined for the most recent 30-day period. The CSR parent/caregiver status indicators follow:

11a. **CAREGIVER SUPPORT OF THE CHILD:** • Are the parents or foster caregivers with whom the child is currently residing willing and able to provide the child with the assistance, supervision, and support necessary for daily living? • If added supports are required in the home to meet the needs of the child and assist the caregiver, are these supports meeting the needs?

11b. **GROUP CAREGIVER SUPPORT OF THE CHILD:** Are the child's primary caregivers in the group home or facility supporting the education and development of the child adequately on a consistent daily basis?

12. **PARENTING CAPACITIES:** To what degree: • Does the parent, with whom the child is currently residing (box A) and/or has a goal of reunification (box B), present or experience a pattern of significant, on-going challenges that substantially limit or adversely affect the parent's capacity to function successfully as an adequate, reliable caregiver for this child?

13. **CAREGIVER PARTICIPATION IN DECISIONS:** • To what degree are the child's caregivers ongoing participants (e.g., having a significant role, voice, influence) in decisions made about the child's life situation, educational, treatment, and support services? [Most recent planning meetings]

14. **SUBSTANCE USE:** • Is the caregiver free from substance use impairment? • If the caregiver is in recovery from a substance use disorder, is the family home atmosphere supportive of recovery efforts?

15. **SATISFACTION WITH SERVICES/RESULTS:** To what extent are the child/youth and primary caregiver satisfied with the supports, services, and service results they presently are experiencing?

OVERALL CAREGIVER STATUS: • Based on the CSR findings determined for the Caregiver Status Exams 11–15, how well is this caregiver presently doing? Overall caregiver status is considered acceptable when specified combinations and levels of examination findings are present. A special scoring procedure is used to determine Overall Caregiver Status using a six-point rating scale.

Child Progress Indicators

Presented below is a set of questions used to determine the progress of a child or youth receiving services. A primary focus is placed on the pattern of changes recently occurring for the child. Progress should be associated with treatment goals and services provided to the child and family.

1. **REDUCTION OF SYMPTOMS/SUBSTANCE USE:** To what extent are the target psychiatric symptoms and/or substance use patterns that caused impairments that have led to adverse impact being reduced for this child?

2. **IMPROVED COPING/SELF-MANAGEMENT:** To what extent has the child demonstrated adequate progress over the past six months, consistent with the child's age and ability, in building appropriate coping skills that manage lingering psychiatric symptoms, prevent relapse from substance abuse recovery, and/or gaining functional behaviors and self-management skills?

3. **SCHOOL/WORK PROGRESS:** To what extent has the child demonstrated adequate progress over the past six months, consistent with the child's age and ability, in his/her assigned academic or vocational curriculum or work situation?

4. **RISK REDUCTION:** To what extent has adequate progress, consistent with the child/youth's life circumstances and functional abilities, been made in reduction of specific, targeted risks identified for this child over the past six months?

5. **MEANINGFUL RELATIONSHIPS:** • To what degree has this child made adequate progress in developing and maintaining meaningful relationships with family members, age peers, and adult supporters [at home, at school, and in the community] over the past six months?

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6. **PROGRESS TOWARD INDEPENDENCE:** • To what degree has the youth been transitioning toward living safely and functioning successfully independent of agency services over the past six months? • To what degree is the youth demonstrating a developing ability to live safely and function successfully without outside supervision, assuming that any necessary supports continue after reaching the age of majority?

7. **OVERALL CHILD PROGRESS PATTERN:** Taking into account the relative degree of progress observed for the child/youth on the above seven progress indicators, what is the overall pattern of progress for this child/youth: optimal, good, fair, marginal, poor, or adverse? Overall progress is considered acceptable when the overall pattern is deemed to be fair or better.

PRACTICE PERFORMANCE INDICATORS

Practice is defined as actions taken by staff/providers to join with a stressed family in a change process that increases and maintains family functioning and well-being while reducing risks of harm, hardship, and poor outcomes. Presented below is a set of questions used to determine the adequacy and consistency of practice and service system performance observed for the focus child and family. These questions focus on core practice functions, conditions of practice, and specialized intervention techniques rather than compliance with policies and procedures. The focus of review is placed on "what's working now" for this child and family as well as "what's not working now and why." This approach supports an inquiry approach organized around two basic questions: "Where are we now in practice with this family?" and "What should be done next?" Performance is examined over the past 90 days.

Performance of Core Practice Functions

1. **ENGAGEMENT**: • How well are interveners developing and maintaining a mutually beneficial partnership with the child and family that is sustaining their interest in and commitment to a change process? • To what extent have interveners taken action to form a trust-based working relationship with the child and family that is supporting core practice functions? Is the team open, receptive, and willing to make adjustments to increase family engagement and participation? Are families valued members of the team?

2. **TEAMWORK** • TEAM FORMATION: To what degree: (1) Have the "right people" for this child and family formed a working team that meets, talks, and plans together? (2) Does the team have the skills, family knowledge, and abilities necessary to organize effective services for this child and family, given their level of complexity and their cultural background? • TEAM FUNCTIONING: To what degree: (1) Do members of the family team collectively function as a unified team in planning services and evaluating results? (2) Do actions of the family team reflect a coherent pattern of effective teamwork and collaborative problem solving that benefits the child and family?

3. **ASSESSMENT & UNDERSTANDING:** • To what degree: (1) Is there an understanding of the child and family's strengths, needs, risks, and underlying issues that must change for the child to live safely and permanently with the birth family or a resource family, independent of agency supervision? (2) Are the substantial strengths, needs, and risks of the child and family identified through existing assessments, both formal and informal, so that there is a "big picture" understanding? (3) If the child is not living with the family of origin, have the strengths and needs of the current caregiver been identified?

4. **OUTCOMES & DISCHARGE REQUIREMENTS:** • To what degree are there stated, shared, and understood outcomes and ending requirements for the child and family that specify demonstrated behavior changes, sustainable supports, resolution of any legal issues, and other accomplishments necessary for child and family independence from the service system, leading to successful transitions and closure?

5. **INTERVENTION PLANNING:** • To what degree is child/family-centered, culturally competent, safety focused, evidenced-based, well-reasoned, ongoing planning used in selecting and managing intervention strategies, actions, resources, and schedules that drive child/family change processes forward to attainment of specified outcomes/discharge requirements?

6. **FAMILY SUPPORT:** • Are the caregivers in the child's home receiving the training, assistance, and supports necessary for them to perform essential parenting or caregiving functions reliably for this child? • Is the array of in-home supports provided adequate in variety, intensity, de

CONSUMER SERVICE REVIEW PRACTICE PERFORMANCE INDICATORS

endability, and cultural compatibility to provide for caregiver choices and to enable caregivers to meet the challenging needs of the child while maintaining the stability of the home?

7. **CRISIS RESPONSE:** • Is there timely access to and provision of effective services to stabilize or resolve emergent or episodic problems of an urgent nature for this child and family?

8. **RESOURCES:** • Are the supports, services, and resources (both informal and formal) necessary to meet the identified needs in the ISP/IEP available for use by the child and family? • Are the flexible supports and unique service arrangements (both informal and formal) necessary to meet individual needs in the child's plans available for use by the child and family on a timely, adequate, and convenient local basis? • Are the unit-based and placement-based resources necessary to meet goals in the child's plans available for use by the child and family on a timely and adequate basis? • Are any unavailable but necessary resources identified?

9. **INTERVENTION ADEQUACY:** To what degree are the change-related interventions, actions, and resources provided to the child and family of sufficient power (precision, intensity, duration, fidelity, and consistency) required to produce results necessary to achieve and maintain situational stability, symptom/substance use reduction, planned behavioral outcomes, sustainable supports, resiliency/coping and recovery/relapse prevention, successful transitions and independence from system involvement (as appropriate to this child and family)?

10. **TRACKING AND ADJUSTMENTS:** • How well are those involved tracking the child's/family's interventions, progress, changing family circumstances, and results for the child and family? • Do they communicate (as appropriate) to discuss treatment fidelity, barriers, and what strategies are/are not working? • Are interventions adjusted in response to progress made, changing needs, and knowledge gained to create a self-correcting intervention process?

11. **OVERALL PRACTICE PERFORMANCE:** Based on the CSR findings determined for Service Exams 1-10, how well is the service system functioning for this child now? Overall practice performance is considered acceptable when specified combinations and levels of examination findings are present. A special scoring procedure is used to determine Overall Practice Performance for a child.

Appendix B: Example Summaries from Cases Reviewed

Consumer Services Review – Adult

Person's Status Summary

Placement: Own apartment

People Interviewed: Person, Case Manager, Therapist, Psychiatrist.

Person Facts and Living Arrangements: The person is a 40-year-old white male who has been receiving services at this facility for 3.5 years. He was referred on commitment from an inpatient facility where he had resided for seven months. He had a diagnosis of Schizophrenia, paranoid type with symptoms of paranoia, anxiety, excessive use of alcohol, depression and intimidating behavior toward his ex-wife. He had been homeless at times and jailed for violating restraining orders regarding contact with his ex-wife and two children. Services have included medications for his psychiatric symptoms, case management, therapy to cope with anger and frustration, vocational rehabilitation counseling and assistance with financial, legal and housing services.

Person's Current Status: The person now lives in his own apartment, which is clean and decorated with photos of family and certificates regarding his military experience as a Marine. He now receives SSDI payments and has been working 25 hours per week as a stock clerk for the past two years. T.K. takes his prescribed medications reliably according to him and the staff and these seem to have helped his anxiety and depression and the therapy has helped him to cope more effectively with the anger he feels toward his ex-wife and the frustrations of not yet getting approval to have unsupervised visitations with his two children. He has been involved in legal proceedings for about two years trying to obtain court approval for him to visit regularly with his two children without supervision by a third party. According to the person, his ex-wife has opposed these efforts and has also been pursuing additional child support payments (beyond the child support payments she now receives from the Social Security Administration) from him. The person acknowledges that the issue of visitation with his children preoccupies his thinking and he describes this situation with notable, but controlled, intensity. He is aware that his intimidating behaviors previously were counter-productive and now seems determined to do whatever he can (comply with medications, hold a job, control his anger and continue in therapy) to convince authorities that he is capable of being a responsible and caring parent. He knows he is rather isolated socially but says that he is comfortable with that. He also knows that his current job is "dead end", but does not wish to pursue a higher paying job at this time because he does not want to exceed SSDI income limitations. He no longer uses alcohol.

Factors Contributing to Favorable Status: The person is motivated to improve in order to obtain visiting privileges with his children (a boy now 14 years and a girl now 11 years). Thus, he continues to cooperate with his treatment plan. T.K. performs satisfactorily at his job, maintains his apartment and avoids problematic behaviors with others. His interdisciplinary treatment plan was developed by an ACT team whose members have reasonable caseloads and who have worked together for years. Each member knows his or her role and performs with professional compe-

tence and caring engagement with the person. It is also clear that the person is fully engaged with the plans affecting his life.

Factors Contributing to Unfavorable Status: The legal uncertainties regarding his relationship with his children and his ex-wife's continuing efforts to get additional child support from him place ongoing stress on the person and contribute to his level of anxiety and his emotional intensity.

System Performance

What's Working Now: The treatment plan developed by the ACT team is comprehensive and guided by a belief in the recovery capability of the client. The plan addresses his psychiatric problems and builds upon his strengths to hold a job, manage his money, maintain an independent living arrangement and cope responsibly with his frustrations. The members of the team coordinate their activities, stay in touch with the client's functioning, engage with him sensitively and revise the plan as may be indicated periodically. The effectiveness of the team and the plan is reflected in the progress T.K. has made since entering services. The progress is summarized in the section above regarding his current status.

What's Not Working Now and Why: While the outcome of the legal matters is beyond the role of the treatment team to affect (although they have helped T.K. to find legal representation in the past), the possible failure of T.K. to obtain approval to visit with his children without supervision or to be forced to provide additional child support payments has the potential to destabilize the person's current functioning. The absence of a social support system, as is now the case, could be very significant at that time. Past efforts to encourage T.K. to become more socially active have not been successful.

Six-Month Prognosis/Stability of Findings: The person's functioning is likely to be affected by the outcome of legal matters in the next six months. If those matters are not resolved, his high level of stress may adversely affect his currently relatively stable and adaptive functioning.

Possible Practical "Next Steps": Efforts to fully engage T.K. in discussions of his anger and frustrations regarding his relationships with his ex-wife and his children should be enhanced. Particular focus on coping skills, especially in the event of an unfavorable court decision, might be beneficial. In addition, efforts to encourage T.K. to develop a social support network could be helpful. Finally, T.K. might benefit by helping him to develop some "parenting skills". He realistically expressed his awareness of not having much to offer his children and the uneasiness they and he might feel during their visits

Consumer Services Review – Adult

Person's Status Summary

Facts about the Person Reviewed

- Person's Placement: Lives with Parent

People Interviewed

(6) Consumer, Consumer's Mother, Primary Caseworker, Group Therapist/Program Director, Group Leader/VR Specialist, Psychiatrist

Facts About the Person and Living Arrangement

This consumer is a 50-year-old man who has lived with his mother all of his life. He has one older sister who is married and has two teenage children. His sister lives in another state. At one point the family lived in Florida, but moved back to Indiana and have been living in their current home and community for at least six years.

Prior to his mental illness, the consumer had many years of employment and job stability. He graduated from high school and briefly served in the military. His longest job was as a grocery store clerk. He also enjoyed working at a local restaurant where he cleared tables, and enjoyed the live bands that used to perform in the evenings. The consumer owned a car and did not rely on others for transportation.

The onset of this consumer's Schizo-Affective Disorder occurred when he was in his late thirties. He had become increasingly paranoid about the neighbors who he believed were "out to get him." When he began to state that he wanted to get a gun and that "somebody would die" his mother sought a psychiatric hospitalization. She says that her family did not understand her son's situation at the time and did not support his hospitalization.

Since his first hospitalization, he has been receiving outpatient services at the mental health center. He currently receives medication management, participates in several groups designed to address ADL and employment skills, and has a supported employment coach.

Person's Current Status

The consumer comes to the mental health center four days a week and participates in a number of different groups. The consumer travels to the center from his rurally located home. The groups he particularly enjoys involve community volunteer work at a food pantry and clothing store. He also likes an activity that requires pairing off with another consumer to plan and implement a different community outing each week.

He would like to be working part-time and is hopeful that he will soon be able to find a job. He does not want to return to grocery store work as he worries that it would be more stress than he might be able to handle.

The consumer enjoys a relationship with his older sister, and his teenage niece and nephew. The consumer and his mother go to visit the sister's family several times a year.

Over the course of his outpatient treatment, he received Zyprexa which resulted in a 100 pound weight gain. He has had difficulty losing weight. He currently takes Abilify. He continues to hear voices on a daily basis, and sometimes still experiences feelings of paranoia when he and his mother eat out.

Home Provider's Status

The consumer's mother is 70 years old and works full time as night shift staff in a group home for children. She says that she needs to work in order to continue to receive insurance coverage. She has told the psychiatrist that she is currently on nine medications. It appears that her own personal health concerns are increasing.

This parent has had discussions with her oldest daughter who wants to help care for the consumer when the mother is no longer able. The parent wants to move to her daughter's community now, but the consumer is quite opposed to moving.

Factors Contributing to Favorable Status

The consumer:

- has experienced much stability over the past six years and has not had any hospital admissions;
- has an understanding of his symptoms and the importance of medication in helping to manage his symptoms;
- has a friendly demeanor with staff and other persons;
- cares about his personal appearance;
- has job skills and an interest in employment.

The family:

- mother who has significant investment and commitment to his ongoing care and treatment;
- sister who would like to help with his care when mother is no longer able.

Factors Contributing to Unfavorable Status

The consumer:

- there are no current prospects for his employment;
- still struggles with some daily symptoms;
- does not have expectations/skills for increasing his level of self-care responsibilities in his home setting;
- does not have a plan for his living arrangement when his mother is no longer able to support him; and

- does not have a specific plan in place for losing weight (psychiatrist would like him to lose 75 to 80 pounds).

The family:

- the mother appears to have increasing health problems and is feeling that she can't cope much longer with the demands of caring for her son;
- mother does not want to upset her son with her concerns and does not know of resources/ help available to her;
- is not able to resolve their longer-range plan for where/how they will live in the future and how the mother will be able to get an increase in assistance from the consumer's sister.

System Performance

What's Working Now

- Innovative arrangement with Sheriff to provide transportation for consumers who live in rural areas;
- Strong psychiatric practice including same psychiatrist for six years; psychiatrist has important insights into son's relationship with mother and mother's needs;
- Creative restructuring of group sessions which result in meaningful volunteer opportunities as well as peer socialization opportunities that are a good match to needs of this consumer ("Coaches Corner" and "Helping Hands")

What's Not Working Now and Why

- Team members have important knowledge and information that is not shared and used for strategic planning (psychiatrist knew about daily symptom challenges of consumer and had some important insights into son/mother relationship and issues; psychiatrist not engaged as team member for planning interventions and symptom coping strategies)
- Consumer's mother provides essential caregiving support to son and has not been engaged in treatment planning in terms of the sustainability of current situation and how to plan for her and her son's future needs.
- The consumer's VR approval runs out in two weeks; an extension if approved will only be for a few months. This will further limit ability of staff to find and support an employment situation which is consumer's top recovery goal at this time.
- Team members have not collaborated in discussion about the type of employment and job supports that would be appropriate match for consumer. A nighttime shift job was being sought to match mother's situation for transportation purposes; impact of night work schedule not vetted with other team members.

Six-Month Prognosis/Stability of Findings

Team members believe that consumer will be able to sustain his current progress.

Practical Steps to Overcome Current Problems

1. Engage mother in conversation privately to discuss her needs and concerns as a caregiver. Consider whether family therapy might be an option to help mother and son resolve current issues and futures planning. One goal of family therapy that might be useful would be to achieve consensus as to whether a move to sister's community would be beneficial, and if so, to discuss and assist the mother and consumer plan the steps for this major transition.
2. Primary caseworker, VR specialist should partner with psychiatrist, consumer and consumer's mother to discuss the consumer's ongoing symptoms and specific ways to help consumer with symptom management.
3. Expand consumer's ability to perform volunteer work.

Consumer Services Review – Adult

Person's Status Summary

Person's Placement: Group Home

People Interviewed During This Review:
The following individuals were interviewed during this process:

1. Client
2. Client's Case Manager
3. Client's Group Home Manager
4. Client's Psychiatrist
5. Client's Brother

CR is a divorced 46-year-old white female who resides in a supportive group home. She has a diagnosis of paranoid schizophrenia and history that's significant for a lengthy state hospitalization. In fact, her current placement is that of a state hospital "contract client" that was released on a trial basis to the CMHC. She appears to have been institutionalized in her early-30's, and stayed in the state hospital for at least seven years. She was discharged on a contractual basis to her current setting in February, 2001. She was diagnosed with rectal cancer approximately three months ago and has since undergone a full course of chemotherapy. CR is scheduled within ten days of this report for a follow-up with her oncologist to learn of her remission status. CR has a fairly complete recovery team, with her case manager, group home manager and psychiatrist being the most involved at this point. The group home staff is also quite invested with CR.

CR has a personal care physician in addition to her oncologist. She has attended Day Treatment programming in the past, but her recent health difficulties have precluded her involvement in the services over the last several months.

CR's group home is staffed 24-hours and is a comfortable facility situated in a wooded residential neighborhood. It does not appear to be any different from the other homes in the area from the outside.

Person's Current Status
CR appears to be acutely delusional, poorly oriented and seems intellectually challenged. During our interview she claimed to be 17-years-old and has lived in the group home for 16 years. She has poor social abilities and does not seem to have any meaningful relationships with her peers in the group home. She has a history of verbally lashing out and using foul and derogatory language against strangers, unprovoked. CR does have family who live within a couple of hours driving distance of the group home who visit as much as possible – monthly for the most part – and call fairly frequently. She seems to enjoy the visits, but when asked the names of her brothers replied "Larry and Joseph," when in fact they are Larry and Kevin.

CR had taken and generally prospered on Clozaril in the past, but had to be switched to Haldol

recently because of complications with the medications prescribed for her cancer treatment. She has not functioned as well on the Haldol as her psychiatrist would hope, but she has functioned well enough to maintain her current placement and progress of cancer treatment. According to her psychiatrist she cannot be put back on her Clozaril at this time because it has a "no rechallenge" protocol due to the likely side effects and potential life-threatening risks. Her psychiatrist is very active and aggressive in her monitoring and titration of the medications and communicates her reasons and changes well with the rest of the treatment team.

In addition to her physical, psychiatric and cognitive difficulties already noted, CR is hard of hearing. She often needs very clear, simple and repetitive directives to accomplish her activities of daily living.

The organization serves as the client's payee and gives her spending money on a weekly basis for her to purchase items of her choice. However, the staff has to monitor her purchases as CR compulsively buys multiple amounts of the same item; for example, she will buy four or five bottles of shampoo.

Home Provider's Status

The provider receives the supports necessary to adequately meet the needs of the client. The group home is part of a larger mental health agency that has a full continuum of psychiatric services. The organization utilizes a computerized treatment plan and documentation process that is accessible by all treatment team members. The system also has capabilities of internal communication that notifies staff of medication changes, symptoms and other important information. The case manager working with the client is aware of and utilizes external resources in order to reacclimate clients to the community. However, the providers acknowledge that they would like more information and training on recovery and reintegration models in order to better serve their clients.

Factors Contributing to Favorable Status

The client's case manager is a very skilled and clinically strong provider. She has a keen insight into the client's needs, but also assists her in challenging her limits and doing "normal" things such as shopping and eating at restaurants, albeit supervised. The case manager is very attentive to her role as a case coordinator making sure that all aspects of CR's internal and external provider team communicate and have dialogue concerning CR's status and changes in overall functioning.

The client's group home is also supportive and encouraging while providing a safe, comfortable environment for her.

CR's treatment team would like to transition her back to the day treatment program as well as any other appropriate programming that she can tolerate given her medical and functional level.

Factors Contributing to Unfavorable Status

As stated, the client's overall functional level (physical and mental health factors) is rather low at this time. She has a current Global Assessment of Functioning (GAF) score of 30-32, and has recently undergone an aggressive course of chemotherapy for rectal cancer. If her upcoming biopsy proves that her cancer is still imminent, she will most likely have to undergo more chemo as well more invasive procedures such as surgery. There is a real risk that she will have to use a colostomy apparatus if the cancer progresses.

Her poor orientation, acute delusions and psychosis and hyper-impulsivity will also prove to be unfavorable contributing factors.

System Performance Appraisal Summary

What's Working Now

The client is fortunate to have an attentive, caring and knowledgeable team attending to her care. She has a case manager that case coordinates well, and a psychiatrist who is invested in her care and treatment. In fact, her psychiatrist visits her every nine weeks in the residential facility to complete her medication management reviews and to personally witness her living environment and daily living functioning.

CR also has a caring family that has become more involved and invested in her care especially since the onset of her cancer.

The client has maintained a significant period of relative stability experiencing no hospitalizations or relapse requiring further institutionalization.

What's Not Working Now and Why

Overall, CR is receiving excellent care. Recovery being a relative abstract is an interesting discussion to have in terms of CR's current and future progress, needs and desires. All people interviewed (other than CR) stated that their hopes and desires for CR in the future are that she remains stable, safe and out of the confinement of a state hospital. CR was unable to articulate any tangible future desires, and seems genuinely happy and content in her current surroundings.

The treatment team acts in the best interests of CR and has many concerns about her safety, her risk of victimization and current inability to function independently. However, in doing so (and again, working from the genuine "good place" of concern and compassion), often times opportunities for growth and development might be missed. It doesn't appear that CR has been considered for more active programming such as Clubhouse, nor have potential community partners been sought out such as supervised workshops or external day programs. It might be that the staff has knowledge of prohibitive criteria for those programs, but it should be documented and noted as part of the assessment that reintegrative measures have been or are considered.

Six-Month Prognosis/Stability of Findings

If all things remain in place as they are today, CR will remain stable and should continue to improve physically over the next six months. The only real challenge on the horizon to her stability will be health issues that could continue to impact her mental health treatment and keep her from participating in any other levels of programming.

Practical Steps to Sustain Success and Overcome Current Problems:

As stated, CR's treatment is outstanding. Each key participant is genuinely concerned and operates from a place of true compassion and respect for the client. In doing so, they have become very fond and protective of CR, without stirring any issues of poor boundaries or limiting her progress. However, individuals with the psychiatric and cognitive challenges like CR are often underestimated in their abilities. The team might work with the resident to develop a series of steps and goals that she could work toward to integrate into more community-based activity, as the client seems to really enjoy her excursions to shop and dine in the community. The challenge will be design the steps that provide the client with the unique supports she'll need to progress safely, free of risk of victimization to her or others. The team should examine the advantage it has in terms of its creativity and surrounding community, and continue to work toward defeating the notion that group homes often function as little more than extensions of state institutions. It may take many months, but with consistent assessment and reassessment, the team may start to see some measurable, tangible gains to this end.

Consumer Services Review – Adult

Person's Status Summary

Facts about the Person Reviewed
• Person's Placement: Family's home

People Interviewed during this Review
(4) Case Manager, Psychiatrist, Substance Abuse Specialist, and Supported Employment Coach (Note: Consumer cancelled interview so additional time was spent reviewing chart and past history)

Facts About the Person and Living Arrangement
This consumer turned 23 years of age during the week of the QSR review. He has grown up in the same home in a small rural community in Indiana. He has an older sister who is married with three children and a brother who is currently serving a four-year prison sentence for drug related charges. The consumer lives at home with both of his parents. He has diagnoses of Bi-Polar Disorder with Psychotic Features and Poly-Substance Abuse Dependency. He is currently served by the ACT team.

Person's Current Status
There is not a lot known about this consumer's childhood and teenage years, although there are many indicators of a violent and chaotic home life. He reports being a childhood victim of "all kinds of abuse" including sexual molestation at the age of eight by a friend of his brother. He says that he began tasting alcohol at the age of six years, and smoking marijuana at the age of 11 years. He was frequently truant from middle school and has reported that he drank every weekend during middle school. He was in special education programs, believed to be classes for children with Emotional Handicaps. He dropped out of school in the ninth grade.

When the consumer was 17, he was arrested for dealing marijuana. As a minor, he was placed on probation for a subsequent year of good behavior.

At one point, his cousin was making crank and sugar cube acid in the back room of his family's home. This cousin was arrested, and subsequently served a prison sentence for drug dealing. While in prison, his cousin was assessed as having a bi-polar disorder. The consumer went to the internet and says he read all he could about this disorder, and felt that the symptoms reflected exactly the types of experiences he was having. He said that ever since he was a child he had much difficulty sleeping. At the age of 20, he went on his own initiative to the mental health center to be assessed for a possible bi-polar disorder.

At the time of his first mental health evaluation, he revealed that he had recently tried to stab his brother, and that during an argument with his father his father attempted to choke him. He was assessed as having Axis I: Cannabis Abuse; R/O Dependence; Interim Explosive Disorder; R/O

Cychothymia; R/O PTSD. His GAF at the time was 35.

He agreed to a medication trial of Risperdal and it was strongly recommended that he discontinue marijuana use.

It does not appear that he came back for any follow-up treatment. His first arrest as an adult was eight months later for possession of marijuana. He was given one year of probation with a stipulation that he participate in substance abuse treatment. Four months after his own arrest, his brother began a four-year prison sentence.

The consumer's first psychiatric admission was at the age of 21 years. He had been contemplating suicide, and was feeling "homicidal" towards his father. He reported having ongoing pain in his hip, back, knees and hands. He indicated that he had been prescribed Zoloft, Abilify, and Trazodone, but later in the same assessment said that he hasn't tried any medications to manage his symptoms. During this admission, he also revealed in response to a question about cultural issues in his family that his family "doesn't talk about certain things – abuse." He also believed that his father showed many symptoms of a bi-polar disorder. It was during this admission that staff noted several scars and scabbing on both forearms. After one day, he was discharged to Intensive Outpatient Services (IOP).

His further assessment in IOP revealed that he was self-mutilating and burning his forearms with cigarettes on a regular basis. Again, he revealed thoughts of wanting to kill himself and his father. He said that he had auditory hallucinations of a voice telling him to burn or hurt himself. His judgment and insight were viewed as "grossly impaired." His primary diagnoses at that time were Bi-polar, Mixed with Psychotic Features; Polysubstance Abuse Dependency. His other medications were discontinued and he was started on Symbyax and Campral. The Campral was quickly discontinued due to his substance abuse. Trazodone was tried to help with sleep and later changed to Ambien.

Two months later he had his second psychiatric admission for feeling suicidal. This time he was discharged to the ACT team. Within days, he was admitted for the third time to the inpatient unit. At the time, he was so agitated that he was unable to provide any history or information, other than to say that he was hearing voices. After a 72 hour hold, he was transferred back to the ACT team with a recommendation for SLIP housing.

The ACT team traveled to the consumer's community one day a week to attempt to engage him in services (as well as to see other consumers in this community). He came to two group meetings for persons with dual diagnoses of mental illness and substance abuse. The group is intended for persons who are in the pre-contemplative phase of beginning substance abuse treatment. He received help in applying for SSI benefits and Medicaid eligibility.

He told staff that he wanted to move out of his parents' home, but when housing was arranged for him by the case manager, he changed his mind. He was being trained for "extreme fighting"

and was hoping to participate in a fight for a fee. His trainer was in his home community, and he would have had to move in order to live in the housing offered.

During his first seven months with the ACT team, there were ongoing efforts to assist him in getting a job. He indicated that he would like to learn about computers, and he was assisted in applying for Vocational Rehabilitation (VR) services. He learned that he would need to have some work experience before he would be eligible for training from VR. He went with his Supported Employment coach to get information about completing his GED. He started several jobs that he quit after one day. His best employment success was working for one company for one month last December. His family did buy him a car to use for transportation to his job.

While at this company, he made a new friend who was also had a poly-substance abuse dependency. In January, the two went on a week-long binge with ecstasy which resulted in his fourth psychiatric admission. He was telling staff that he wanted to kill himself. He reported that his primary stressors continued to be "constant conflicts in his home environment."

He was referred back to the ACT team, and his updated assessment at the time recommended that housing, employment, and his substance abuse be addressed. Team members continued to reach out to him on a weekly basis in his home community. Calls to his home would go unanswered, as would knocks on the door. There was only one occasion during the whole time that the ACT team was involved that the case manager actually was allowed into the consumer's home. Most times, when the consumer was available to see the case manager they went out to another community setting to talk. On two different occasions, the consumer was worried that his girlfriend may be pregnant.

For the past four months, there has been one visit with the team psychiatrist. Lexipro and Abilify were provided in a limited amount to ensure that he would follow up to be monitored. He did not return.

During the summer months, the consumer had two separate arrests. One was for a physical assault and OUI (Operating a Vehicle under the Influence). His parents and girlfriend provided him with bail money, although he did spend a few weeks in jail. The other charge was for attempting to steal cough medicine. He again made a suicide attempt by taking an overdose of sleeping pills, which resulted in getting his stomach pumped at the hospital emergency room. He was transferred to the in-patient unit, where he revealed that he was drinking to the level of intoxication three to four times a week and experiencing black-outs. His judgment and insight were determined to be "fairly intact" and he was discharged in 24 hours to his parent's home.

In the past month, he called a member of the ACT team to take him to the hospital for pain in his stomach. He learned that he has a bleeding ulcer. He also learned that his Medicaid had expired, along with his other benefits. He contacted his case manager to help him reapply for Medicaid, and they were able to get the process initiated. He asked the case manager to go with him to his court hearing the following week.

At the hearing, he was placed on two years of probation. The conditions for probation included a 90 day suspended driver's license; monetary fines; an evaluation for Alcohol and Drugs and follow-up on recommendations at the mental health center; and a requirement to complete his GED.

Home Provider's Status
There has been almost no contact with this consumer's parents. There have been rumors that both parents use/abuse substances. On a few occasions when the father has been at home when staff have come to visit the consumer, he has avoided any attempts at communication.

Factors Contributing to Favorable Status
This consumer:

- can be articulate and insightful;
- is honest about his substance abuse;
- is very motivated to not go to prison and follow brother's footsteps;
- does reach out to team members at time of critical need; and
- has an older sister who appears to live a fairly stable life on her own.

Factors Contributing to Unfavorable Status
The consumer:

- is not receiving adequate health care for bleeding ulcer and joint/back pain that he complains of;
- has increasing severity of substance dependency, black-outs, an OUI and current legal consequences;
- has fighting skills that have recently resulted in harm to another person and his own arrest;
- has consistently conveyed thoughts of extreme anger/aggression towards his father and remains at home with him;
- is not receiving any treatment, including medication, for his bi-polar disorder.

System Performance Appraisal Summary

What's Working Now
This team:

- has been persistent in providing outreach to this consumer on a weekly basis in his home community;
- has engaged him to the extent that he trusts them in times of critical need;
- understands the severity of his dual diagnosis;
- now has some new leverage with current terms of new probation order.

What's Not Working Now and Why
The system:

- does not yet have an understanding of the dynamics in the family home that the consumer

refers to as “past abuses” as well as “ongoing conflicts”
- does not have a clear system protocol for collaborating with probation in case planning and monitoring;
- has not yet found a way to engage the consumer and possibly some family members in planning for his recovery, to have some choices and influence over the direction of interventions that will be the best match to his needs;
- there is no safety/crises management plan in place with this consumer and/or his family.

Six-Month Prognosis/Stability of Findings

This consumer is at great current risk for harming himself or another person. His status is expected to decline if the team continues to be unable to engage him in any treatment interventions.

Practical Steps to Sustain Success and Overcome Current Problems

This has been a difficult and challenging consumer for this team. They will continue to reach out to him. During the debriefing, the team did some brainstorming and came up with the following additional steps that might help to engage this consumer:

1) Explore with probation the possibility of having a joint planning meeting with consumer to see what he needs to successfully meet the conditions of probation. Ensure that the probation person can assist with articulating the consequences of not meeting probation requirements. (Building on the consumer’s desire not to go to prison.)
2) Explore whether the consumer would ask his sister to participate as a supportive family member in the planning meeting. (This would be particularly helpful in learning more about the consumer’s family situation at home.)
3) Obtain his school records to learn whether he has any learning disabilities that need to be considered in terms of how he will obtain his GED
4) Seek more medical information as to the reason for joint pain.

Consumer Services Review – Child

Person's Status Summary

Facts about Child and Family

Child's Placement: Home *System of Care*

Persons Interviewed

The child, mother, special education teacher, regular education teacher, regular education teacher from last year, principal, assistant principal, Certified Nurse Practitioner, social worker, and therapist were all interviewed during this review.

Facts about the Child and Family

TE is a 9-year-old bi-racial male in the 3rd grade. His biological parents separated when TE was age 4 and divorced when he was age 7 due to physical and emotional abuse by his biological father.

TE began displaying aggressive behaviors in preschool. Behaviors were present at home and school and included hitting peers, his mother, and his sister, throwing objects, verbally intimidating teachers, and property damage. TE began receiving outpatient therapy services in preschool. In August of 2004 TE began receiving school-based mental health services as aggressive behaviors continued across settings. TE also became eligible for special education services at this time for Emotional Disability. In February 2005, the treatment team decided that TE needed a more structured educational setting and behavioral supports in the classroom and he was placed in a Children's Day Treatment Program (CDP). TE had a severe aggressive outburst and was placed at an inpatient psychiatric hospital immediately. The mother removed him Against Medical Advice following a chemical restraint incident with TE. TE then returned to the CDP and showed an improvement in academic and behavioral functioning. TE transitioned back to his home school in April 04.

In October 2005, TE began displaying increasingly more aggressive symptoms. The treatment team had a series of meetings and decided to place TE at an alternative learning center. The center was a self-contained special education classroom with diagnostic educational services and was located at an elementary school. TE was at the alternative learning center for 60 days and then transitioned back to his home school.

Child's Current Status

TE is currently in the 3rd grade and is reading at grade level. His teachers report some difficulties with reading comprehension. He is in a regular education classroom with special education pull-out for reading and social skill building. His grades have improved and he is reported to be performing at his academic ability.

TE lives with his biological mother, step-father, and two younger siblings. He has sporadic con-

tact with his biological father and has recently told his mother that he no longer wants to visit his father. The mother reports that following the most recent weekend at his father's, TE began acting out aggressively at home.

TE is currently taking Adderall and Geodon and sees a Certified Nurse Practitioner once a month. His current diagnoses are Generalized Anxiety Disorder, Oppositional Defiant Disorder, Dysthymia, and Attention Deficit Disorder by history. There is a maternal history of anxiety and paternal history of substance abuse.

TE participates in a System of Care program in which services are coordinated by one person across settings. The social worker is employed by the mental health center, however, is located at the school. She provides case management and coordination services as well as individual therapy and support to TE and his family.

TE receives group therapy services once a week for 90 minutes and meets with an individual therapist several times a month. The group addresses social skills and feelings-management skill building. The therapist addresses behaviors at school and home and coordinates all aspects of services for TE.

TE transitioned from an alternative learning center in February 2006. The transition was well planned and well executed. TE was gradually reintegrated back to his home school. The plan included partial days at each school with TE accompanied by a male mentor.

Team members describe TE as using more appropriate coping skills for dealing with frustration and as using appropriate verbalizations when asking for help and when expressing his feelings. TE is also described as taking ownership and responsibility for his behaviors, as thinking before acting, and as walking away from conflict with peers.

TE is a friendly boy who likes to play baseball and sports and who is good at reading. TE stated that his favorite subject at school is math.

Caregiver's Status

TE's mother reports that she is well supported with parenting TE. She is comfortable contacting the therapist regarding supports and interventions for herself and TE. The mother reports that the supports and services in place for TE have also taught her better coping skills for parenting a youth with emotional and behavioral difficulties.

Factors Contributing to Favorable Status

There are many factors contributing to favorable status for this youth, primarily, the strong functioning level of the team. This youth has achieved and is sustaining positive outcomes also because of a high functioning, engaged, and appropriately advocating parent; no turnover in team members; mental health workers located on school campus; a single point of coordination and contact, and the use of an array of evidence-based interventions. The overall Child Status Rating

for this youth is 5-substantially acceptable/maintain.

Factors Contributing to Unfavorable Status
At this time there are no factors contributing to unfavorable status. The youth is sustaining the progress gained and the team/system is functioning with a high level of integrity.

System Performance

What's Working

- This team is very cohesive and unified in their approach to problem solving for TE.
- Medication management aspect is strong. The Certified Nurse Practitioner is well informed and is a participating member of the team.
- The team uses strengths based problem solving techniques and builds interventions based on what is known to work for the youth.
- The team did not give up on the youth and family when things got difficult. Team members continued to engage, work with, and support the parent and youth.
- Team members have a depth of understanding. They know and understand all of the factors contributing to this youth's behaviors and needs.
- Transition was well thought out, well planned, well executed and the youth has sustained positive outcomes.
- The treatment team is continuing to plan ahead for future transitions.
- The team was focused on outcomes for this youth and family.
- No turnover in team members.

The above listed strengths contribute to the overall System Performance rating of 5-acceptable/maintain.

What's Not Working and Why
Not applicable at this time.

Six-Month Prognosis
Based on the recent and sustained progress and the high functioning level of the team, TE is expected to improve during the next six months.

Practical Steps to Sustain Success
It is suggested that the team continue to function as it is currently. The team should continue to look forward and plan upcoming transitions with the same detail as the transition from the alternative learning center back to his home school. Continued support for TE and his family with strengths-based approaches and problem solving would also be suggested.

Consumer Services Review – Child

Person's Status Summary

Facts about Child and Family
Child's Placement: Biological Family

Persons Interviewed During the Review (total 4): child's therapist, child's schoolteacher (phone interview), mother, and child were all interviewed for this review. The psychiatrist was scheduled to participate in this review but was absent due to illness.

Facts about the Child and Family
MM is a 10-year-old Caucasian female currently living with her biological mother, younger brother, and mother's boyfriend. MM began services in 2000 when following her parents' divorce she began displaying defiant and aggressive behaviors, such as biting, hitting, anger outbursts, and self-injurious behavior (biting herself). There was a history of domestic violence in the home prior to parents' divorce. Due to mother's illness, MM was placed with her father and stepmother after the divorce but as a result of physical abuse by stepmother, CPS removed MM from the home and placed her with her mother. Due to unsafe anger outbursts and suicidal ideation, MM has already been hospitalized three times, the last time being in October 2006. She has gotten so aggressive that her outbursts have resulted in property damage in the home, such as denting the stove and punching holes in the walls. She has bitten her mother and mother's boyfriend on several occasions. She has had several diagnoses and prescribed different types of medication. No accurate IQ is available at this time; however, it is believed that it ranges from 65 to 85. She is currently in 3rd grade, there is an IEP for MM and, according to her mother and teacher, she is likely to repeat 3rd grade.

Her current treatment addresses age-appropriate expression of feelings and safe conflict resolution. She is making significant progress in individual therapy, where she is developing a strong therapeutic rapport with her therapist and learning safe expression of feelings. Recently, she has been diagnosed as having youth bipolar disorder and is currently taking Risperdal. Mother states that she agrees with the diagnosis. The most recent DSM multi-axial diagnosis, from July 2006 is as follows:

Axis I:	Bipolar Disorder
	Oppositional Defiant Disorder
Axis II:	Borderline Intellectual Functioning
Axis III:	Seasonal Allergies
Axis IV:	Problems with the primary support system, history of child abuse
Axis V:	GAF 55

The current treatment plan addresses the following: decrease and extinguish unsafe and disruptive behaviors, develop and sustain age-appropriate communication and relationships, develop

appropriate expression of feelings, increase safe relationships with family members, siblings and peers. It is worth noting that MM does not exhibit any aggressive behaviors in school. They only manifest in the home environment. Consistent with therapist and mother, the teacher observes that MM "is coming out of her shell."

MM sees her therapist twice a month. Her brother is also seeing a therapist at the mental health center. Therapist reports that she and MM's brother's therapist are in constant communication regarding the treatment, progress, and needs of the family. At this moment, there are no case management services in place. Therapist would like to refer a particular case manager to this family; however, that case manager has been on maternity leave for a few weeks. Therapist is waiting for case manager to return to initiate services. A case manager would be highly beneficial in this case so that she could provide in-home supportive counseling, redirection, support to parents, develop a safety plan, and maintain ongoing contact with the school.

Per conversation with the schoolteacher, MM is displaying improved social skills, "coming out of her shell," developing peer relations, completing her work and participating in class. However, she is not meeting the expectations of her IEP. The teacher does not observe any inappropriate or unsafe behavior by MM in her class. Teacher reports that MM's attendance is good. Despite being in 3rd grade (MM is 10 years old), she possessed a 2nd grade reading level. MM is receiving special education on a part-time basis. MM did not pass the ISTEP test.

MM is described by all persons interviewed as improving in behavior and learning, becoming increasingly social, being good at spelling, cooperative in the home as evidenced by helping her mother with home chores, talented at drawing, athletic, intelligent, caring and generous.

Child's Current Status

The overall rating for Child Status is rated 5-acceptable/maintain. All parties involved in MM's care observe progress in her ability to become more pro-social, communicative, and playful. According to her mother, the frequency and intensity of anger outbursts has decreased and MM is more capable at de-escalating her outbursts. Ever since she was hospitalized last time in October 2005 and was subsequently prescribed by a psychiatrist at the mental health center who also diagnosed her as having Bipolar Disorder, her overall attitude and behavior have improved. At this moment, MM is not receiving family therapy or case management services. Mother reports that MM complies with medication treatment.

Caregiver's Status

The overall rating for Caregiver Status is rated 5-acceptable/maintain. Her mother is supportive of MM and, despite her feeling burned out and overwhelmed by managing her behavior, she is a consistent presence in her life. On one occasion, MM bit her mother on her hip for which she had to go to the emergency room and be administered a Tetanus vaccine. Before beginning to take Risperdal, MM's anger outbursts would result in denting the oven, punching holes in the walls, and hurting others. Yet, her mother has been patient and supportive toward her. When she was informed of the bipolar diagnosis, mother went to the library and researched the criteria for such

diagnosis. In the end, after educating herself, she agreed with the diagnosis and regards the mental health center staff as very helpful. Thus, she is highly satisfied with the services she receives there. Her mother participates in services and displayed an open and generous attitude while being interviewed for this review.

Factors Contributing to Favorable Status

The overall rating for Practice Performance is 5-acceptable/maintain. The rationale for this rating is based on consistent communication between MM's therapist and MM's brother's therapist. In addition, MM's therapist displays foresight, professionalism, and excellent rapport building skills. It is known that at the beginning of individual sessions, MM refused to talk and all she did was mimic her therapist. As of today, MM is becoming more open, talkative, and receptive. The psychiatrist appears to have made an accurate diagnosis of MM. The team appears to be well-informed about the family history and situation. Symptom reduction and behavior changes are well documented and MM is praised for her accomplishments. The services provided to MM and her family are adequate; however, the presence of a case manager would likely foster and role-model appropriate parenting skills for the parents.

Factors Contributing to Unfavorable Status

Despite her patience and commitment to MM, mother appears to be overwhelmed. She works as a CNA at a local nursing home. Her job is highly demanding. MM presents with several challenges, which on occasion have resulted in property damage and injury. In this light, the presence and support of a case manager who provides in-home support is crucial. In addition, as reported by MM's mother, the family does not have a comprehensive safety or crisis plan developed with the mental health center staff. Considering all the challenges in communication and relationships in the home, family therapy would offer the family system to address feelings and concerns in a sound therapeutic environment. Finally, efforts need to be made in order to support MM's successful academic performance for the rest of the year and assess the effectiveness and appropriateness of special education services currently being offered to her.

System Performance

What's Working

1. MM has remained under the care of her biological mother ever since she was removed from her father. Despite MM's highly disruptive and unsafe behavior, her mother displays patience, love, and a strong commitment to help her.

2. Both mother and MM perceive mental health center staff as one of the sources of support and state that they are satisfied with services.

3. Recent assessment and medication adjustment have benefited MM and the family.

What's Not Working and Why

At this moment, there appears to be improvement in MM's attitude and behavior. The anticipa-

tion and preparation for possible crises needs to be examined. The anticipation that she would repeat 3rd grade is a concern. It needs to be explored what additional support MM needs in order to prevent this.

Six-Month Prognosis

The six-month prognosis for MM is improvement. If current services, supports, and housing situation remain stable, it is likely that MM will continue to improve. However, additional resources and support need to be added to complement this improvement.

Practical Steps to Sustain Success

Despite MM's marked improvement, it is recommended that:

1. Case management services be put in place soon in order to coordinate with the school and provide mother with age-appropriate parenting skills.
2. The family and the team must come together to design a crisis/safety plan to assist the family with dealing with MM's unsafe outbursts.
3. Family therapy is strongly suggested so that all family members might have a voice to express their feelings in a therapeutic environment.
4. Efforts need to be made to prevent MM from repeating 3rd grade. It is likely that the appropriateness and effectiveness of current special education services will have to be re-evaluated.

Consumer Services Review – Child

Person's Status Summary

Child's Placement: With biological mother

Persons Interviewed During Review: Total = 4; Child, biological mother, psychiatrist, therapist.

Facts about the Child & Family:
AJ is a 12-year-old Caucasian male currently residing with his biological mother, 4-year-old full sibling (sister), and his "surrogate" grandmother. AJ has an 18-year-old full sister and a 21-year-old half-sister who reside out of the home. AJ's mother and biological father have recently separated and divorced. Father has sporadic contact with AJ and his family. One week prior to review, father was temporarily living with AJ because he lost his job (reported by therapist). AJ was referred for services over 3 years ago due to presented difficulty with emotional regulation and social skills, defiance toward his parents, and poor physical coordination and speech patterns. He currently receives medication management services every 2-3 months, biweekly individual therapy, and weekly group therapy. AJ has no services through outside agencies, as he is homeschooled and has been since beginning school.

Child's Current Status: **Overall Child Status = 3**
AJ has experienced several significant changes in his life over the past 6 months, which include moving to a new town, loss of peer group, and separation and lack of contact with his father. He has difficulty coping with changes in his day-to-day life, so the past several months have been quite a challenge for him. AJ reports sadness regarding his changing relationship with his peer group and his father. He is having a hard time meeting and assimilating in his new neighborhood. He reported fears about "turning into a punk," as he has at times become hostile and aggressive toward others in order to be accepted by peers. AJ misses his friends in his former neighborhood. He has concerns regarding a history of physical violence and severe arguments between his mother and father. He does not feel that the arguments will end soon, but does report that domestic violence has decreased since his parents' divorce. AJ reported that the last few encounters with his father have been "bad," as he and his father have been fighting as well. AJ likely stand ups to his father in order to protect his mother.

AJ has been homeschooled his entire educational life and reported that this approach is currently "not working" for him. AJ has had minimal educational assignments since the beginning of this school year. He discussed his mother's difficulty in preparing appropriate assignments for him and in challenging him regarding his education and needs. AJ appears to be highly isolated from his peer group, as he has no peer exposure within his school setting and currently has few friends in his new neighborhood. He participates in no community activities, but does report that his mother is teaching him how to play baseball.

AJ recognizes the benefits he receives from his services from the mental health center. He enjoys his participation in group and states he is open to continued help in the future. He did state that he cannot control himself without his prescribed medication (Adderall, Lamictal, Lexapro, and Seroquel at bedtime).

Caregiver's Status: **Overall Caregiver Status = 4**

Mother recently began weekly individual therapy with a separate therapist. She reports that this provides her an opportunity to address her own issues, including the "downfall of her marriage." AJ's therapist reports that mother is better able to focus on AJ's treatment now that she is working separately as well. Mother is currently not working outside of the home. She receives significant support from AJ's live-in "surrogate" grandmother. Mother reported frustration with her lack of resources and provider choices within the care of AJ and his younger sister. She does have some feelings of being overwhelmed regarding the demands of caring for her 2 special needs children, while also continuing her struggle within her relationship with AJ's father.

Factors Contributing to Favorable Status:

Currently, AJ is safe and is placed in a permanent home environment with caregivers who desire to meet his basic needs. Mother and "surrogate" grandmother are highly committed to assisting him in whatever way they can. AJ is intelligent and demonstrates potential to succeed in an appropriate school environment. He desires to be more challenged educationally. AJ, mother, and psychiatrist report satisfaction with AJ's current stability and medication regimen. AJ reports enjoyment of his services and progress in group therapy. He states that his medication and services assist him in controlling himself and using appropriate coping skills.

Factors Contributing to Unfavorable Status:

At this time, there is significant concern regarding AJ's educational and social needs. He has very minimal school requirements at this time and is making no educational progress. Mother reports that he reads very well, but that he is highly challenged by handwriting and would prefer to type instead of write by hand. Additionally, AJ has minimal contact with same-age peers because he is not enrolled in a school program, extra-curricular or community activities, and has minimal friends within his new neighborhood. He and his family are very isolated with the exception of services at the mental health center.

AJ's family situation has been difficult over the past few months. He reports loss of positive contact with his father, as he and his father fight frequently during their contact. The divorce has also led him and his family to move to a new apartment, leading to the loss of his peer group.

Therapist reported concerns with mother and child's ability to transfer progress from therapeutic session to the home environment. Mother appears to have difficulty with setting limits and emphasizing structure and routine within her home environment, as evidenced by AJ's history of insomnia and difficulty with evening routine. He often does not go to sleep until well after midnight and will sleep in until noon or after.

System Performance Appraisal Summary: Overall System Performance = 2
The child is currently receiving individual therapy on a biweekly basis, group therapy (addressing social skills) every week, and medication management services every 2-3 months. Mother is receiving individual therapy on a weekly basis. AJ and mother are seeing separate therapists, although his individual therapy and group treatment in provided by the same clinician.

What's Working Now:
Both AJ and his mother report satisfaction with services and plans for continued involvement in treatment. There have been positive efforts toward engagement of AJ and his mother over the past 3 years in treatment. Mother reports ability to provide input into treatment for herself and her son. AJ, mother, and therapist report observance of his progress over the past months, especially within areas of coping, emotional regulation, and social skills. His participation in services is providing him opportunity to engage in a structured environment through completion of group therapy, as well as providing him with time to spend with peers.

What's Not Working Now and Why:
AJ's receipt of services over the past 3 months has minimally addressed the changes he has experienced within his family and external environment. His treatment is primarily addressing his coping skills, emotional regulation, and social skills, instead of his familial changes, move to a new home, loss of relationships, and educational needs. AJ and mother are making progress in individual sessions, but AJ's therapist reported that little change occurs within the home environment. No home-based and/or case management services are currently in place in order to encourage transference of progress from in-session to the home.

Little communication is currently occurring between the therapists involved with the family, as well as the psychiatrist prescribing medication for AJ. There is formation of a treatment team on behalf of the child and family, although key players (case manager, educational representatives, mentor) have not been included within treatment at this time. Additionally, there are minimal plans established outlining ongoing criteria for progress and plans for discharge. AJ and mother have very few sustainable supports within the agency and the outlying community. There is currently no crisis plan in place, although violence has occurred between mother and father, as well as between AJ and peers in the neighborhood that has involved law enforcement officers.

Furthermore, AJ's educational needs are not being met at this time. Therapist reported intent to contact Child Protective Services if this situation does not change within the next few weeks. However, no case manager is assigned to this child/family in order to provide increased intervention and assistance in order to address AJ's educational and social needs.

Six-Month Forecast/Stability of Findings:
It is most likely this case will decline or deteriorate during the next six months. This prognosis is based upon AJ's current instability within his family and home environment, lack of peer relationships, loss of familiarity of previous neighborhood and peer group, and continued unmet educational and social needs through homeschooling with inadequate accountability and assign-

ments for AJ's age and ability.

Practical Steps to Sustain Success and Overcome Current Problems:

1 Implement case management services (including home-based services) in order to address AJ's educational situation, provide continuity of treatment goals from center to home, increase AJ's involvement in social interaction with peers, and provide mother with support within the care of her children while addressing her own needs.
2 Complete psychological and/or pyschoeducational testing in order to clarify diagnoses, determine AJ's present IQ, and assess educational functioning and needs.
3 Contact Child Protective Services or the Department of Education should AJ's current homeschooling scenario continue to be minimally addressing his educational needs.
4 Implement mentor services (ideally with a male) in order to encourage AJ's involvement in community activities where he will have opportunities to interact with others outside his home and establish meaningful relationships with peers and adults.
5 Increase communication within participating team members in order monitor progress, discuss presenting concerns, and determine plans for discharge.
6 Discuss with mother and the child the possibility of initiating family therapy in order to address familial relationships and boundaries within the family.
7 Assist mother in accessing needed supports to assist with the care of her children.
8 More fully explore a crisis plan, should the current living situation become more unstable (due to history of violence between mother and father) and AJ continue to have aggressive encounters with peers.

Consumer Services Review – Adult

Person's Status Summary

Facts about the Person Reviewed
Consumer's Placement: Home

Persons interviewed
Director/job developer, psychiatrist, mother, father, older brother, and the consumer were all interviewed for this case review.

Facts about the Person and Living Arrangement
AC is an 18-year-old Caucasian male. He was initially referred for services in 1995 by the child welfare department. He became involved with the welfare department between the ages of 3 and 5 due to severe neglect by his parents and sexual abuse by his older sister. He was placed in multiple foster homes, reunified with his parents, removed again a year later, and then placed with a foster family for at least a year. He experienced several residential and hospital placements prior to the age of 10. He was reunified with his parents and brothers and involvement with the welfare system ceased, although the time frame for this is unrecorded in the mental health center's record.

A 1995 psychological evaluation notes involvement with special education. The record also noted disruptive, aggressive, and oppositional behaviors at school along with academic difficulties. No other educational information was present. Staff report that AC was permanently expelled from school in the 8th grade for throwing a chair. Staff also report that he reads at about a 3rd grade level and has poor math skills. No IQ data or information was reported, although staff report that he is probably at a low average range of intelligence.

AC's current diagnosis is Attention Deficit Hyperactivity Disorder, Combined type and Victim of Abuse. Past diagnoses include Depression; Abuse of Child, victim; Anxiety, ODD; Adjustment Disorder, and r/o Bipolar Disorder. According to the records, AC underwent brain surgery for two cysts located on his brain stem.

There is a family history of mental illness. The mother suffers from profound depression, two of AC's siblings are depressed and one is mentally handicapped and extremely violent. The father is reported to be a pathological liar and suffers from multiple physical challenges and ailments.

Past treatment concerns and goals included: Difficulty controlling anger; daily confrontations with family authority, and peers; and yelling and swearing at others. Past treatment approaches include multiple medication trials, DBT, CBT, reality therapy, expressive therapy, individual, group, and family therapy. There is no history of substance abuse. Some progress notes indicate that AC occasionally drank beer as an adolescent.

Records and staff report a history of sporadic compliance to treatment interventions by both AC and his parents.

Consumer's Current Status
AC is currently living with his parents, older brother and his fiance, and younger brother in a two-bedroom home. AC has his own space in the dining room that is closed off by a curtain. Records and staff report that AC continues to have some conflict at home, primarily with his mother.

AC reported that he wants a place of his own and a job to support himself. He stated several times to reviewers that he wants to be responsible and pay for himself. AC is close to his family and reported that it is important for him to be available to help his family.

AC discontinued taking medications about two weeks ago of his own accord. He reports feeling better since being off the meds and that he felt he was becoming dependent on the medications. Parents reported no notable change in behavior, neither improvement nor decline.

The current treatment plan lists the following treatment goals and objectives for AC: improve anger management; appropriate self-assertion and advocacy; and assistance with obtaining employment. Staff also stated that AC would like to live in his own place and have a girlfriend. AC reported to reviewers the same goals and acknowledged that "the anger is just always there, it is something that is always on."

AC did not graduate from high school and reports that he was permanently expelled at age 16 and in the eighth grade. He is not currently employed and has completed some applications without success. Staff report that AC has poor social skills and would work better in a job that does not involve a lot of contact with people. AC reported that sometimes he does not feel well and knows that he cannot have personal problems interfere with work. He did work during the past few summers selling ice cream in a nearby area. He reported, however, that he needs a full-time job and the selling ice cream is seasonal.

AC is motivated to have a job, to live in his own place and cares deeply about his family. He has completed the necessary paperwork for SSI and Medicare assistance. AC was also offered a place in a transitional housing unit that is less than a mile from his home. He refused the placement as he felt it was not close enough to his family.

Caregiver's Status
AC is currently living with his parents and brothers. All family members have mental health issues and the father has multiple physical needs. AC has transitioned to an adult-child role in his home and is looking to support himself either in his father's home (his current living situation) or in a place of his own. At this time there appears to be a slight decrease in the conflict at home, although it is reported that he still has arguments with his mother. AC also provides some physical support in helping care for his father.

Factors Contributing to Favorable Status

The system performance is rated 4-minimally acceptable overall. Many of the ratings for system indicators fall between 3 and 4. Team members have a strong, comprehensive understanding of AC's needs and core issues. The psychiatrist noted that the current ADHD diagnosis does not fit well for him. Team members have spent the past two years working to find a diagnosis that is accurate. She reported that team members are working with AC according to his personal goals, current behaviors, current abilities, and presenting symptoms, rather than focusing on the ADHD diagnosis.

An additional strength to be noted is that the recovery goals at the mental health center, both written and understood, match AC's recovery goals. During staffings and treatment team meetings, team members report that there is a "circling back" to consumer stated recovery goals during discussions that keep them focused on their direction.

The third strength noted in the system performance is medication management. AC spent 10 to 25 minutes with reviewers discussing medication, changes, how each medication affected him, and the choices he has made regarding his medication. AC reported that he recently decided to discontinue his medications, as he did not feel they were really helping him. The psychiatrist was aware of this and had contact with him about this decision. AC presented as well-informed and empowered regarding his medications.

An additional strength is that team members are doing what is necessary to work with AC on his recovery goals. The Director of Clinical Services is also serving as a job coach or case manager. All team members are adhering to a recovery model approach with AC.

Although person status was overall rated 3-unacceptable, he is not currently displaying unsafe, aggressive, or oppositional behaviors, his current living situation is minimally appropriate, and for the most part he is satisfied with services.

Factors Contributing to Unfavorable Status

Although some behaviors appear to have decreased, anxious, depressed, and angry symptoms are still present for AC. He is lacking a voice and role in his recovery due to lack of follow through on his part and minimally acceptable engagement efforts on the part of team members. Employment, recovery, and social integration efforts are underpowered. Treatment team formation and functioning are also underpowered as there is no true point of coordination and contact. AC's primary point of contact is also the Director of Clinical Services. Additionally, the center has a new scheduling system that requires consumers to call in and navigate a computerized system. AC has expressed frustrations with the system and team members are aware; however this is a barrier for someone who already has difficulties participating in services.

System Performance

What's Working

Some treatment team members are working outside of their roles and team members walk and talk a true recovery model of practice. AC could have easily fallen off the radar screen several times in the past two years (since expulsion from school) and team members have worked to keep him connected in any way possible. The strong understanding of AC, his needs and issues paired with team members not having limitations to working with him (diagnosis, funding or billing, lack of staff, position or role), and team members working from a recovery model of practice, are what is keeping AC from slipping away from services towards poor outcomes. These factors are supporting the minimally acceptable rating for practice performance.

What's Not Working and Why

The lack of a true coordinator and person who can work with AC more regularly and the general lack of intensity of interventions are what is most impacting AC at this point.

Six-Month Prognosis

Taking into account the current status of AC and the system, it is likely that he will decline in the next six months. The lack of a central point of contact/coordination, the lack of intensive outreach, and the presence of a cumbersome scheduling system, if continued, will not set AC up for progress.

Practical Steps to Sustain Success

- Identification of a case manager or coordinator

- A person to implement intensive outreach efforts to fully engage AC in a recovery model of treatment, assist in improving social integrations, and intensify the pursuit of employment would benefit him immensely. AC does not meet the eligibility criteria for ACT services; however he could benefit greatly from intensive outreach efforts.

Appendix C: Aggregate Demographic Summary Data

CSR/Adult Status and Performance Profile - 6 Point Analysis

Number of cases: 156

Status of the Person (Part 1 of 2)

Combined Data

no PT data

Total Number		1a. Safety person	1b. Safety Others	2a. Income adequacy	2b. Income control	3. Living arrange.	4a. Social net: comp	4b. Social net:recov.	5a. Satisfac person	5b. Satisfac c'giver
Unacceptable										
Improvement	1			1			4	6		
	2	6	3	13	4	3	15	21	4	
	3	11	3	22	17	16	40	43	8	2
Acceptable										
Refinement	4	35	27	54	31	35	56	49	33	7
	5	82	56	62	35	85	41	37	86	26
Maintenance	6	22	13	4	12	17			20	11
Not Applicable			54						3	109
Summary										
Total Acceptable		139	96	120	78	137	97	86	139	44
Total Applicable		156	102	156	99	156	156	156	151	46
Percent Acceptable		**89%**	**94%**	**77%**	**79%**	**88%**	**62%**	**55%**	**92%**	**96%**

Status of the Person (Part 2 of 2)

Total Number		6. Health/Phy well-being	7. Substance use	8. MH status	9. Voice decisions	10. Edu/career prep	11. Work	12. Recovery activities	**13. Overall Status**
Unacceptable									
Improvement	1		4	1	5	12	11	7	**1**
	2	4	5	9	12	14	15	21	**7**
	3	26	12	44	20	8	18	43	**28**
Acceptable									
Refinement	4	48	11	57	55	12	20	41	**64**
	5	73	24	38	57	7	13	31	**54**
Maintenance	6	5	13	6	7	3	2	1	**2**
Not Applicable			86	1		100	77	12	
Summary									
Total Acceptable		126	48	101	119	22	35	73	**120**
Total Applicable		156	69	155	156	56	79	144	**156**
Percent Acceptable		**81%**	**70%**	**65%**	**76%**	**39%**	**44%**	**51%**	**77%**

Recent Progress

Total Number		1. Psych. symptoms	2 Sub. use impairment	3. Personal respons..	4. Edu/wk progress	5. Recovery goals	6 Risk reduction	7. Success. life adj.	8. Social integration	9. Personal relationships	**9. Overall Progress**
Unacceptable											
Improvement	1	1	1	2	11	9	4	2	5	8	**1**
	2	4	6	16	14	28	12	12	16	17	**14**
	3	40	9	36	20	35	22	26	51	41	**40**
Acceptable											
Refinement	4	60	15	50	20	37	32	49	39	50	**63**
	5	44	19	44	11	29	31	35	33	29	**36**
Maintenance	6	1	4	2	2	2	2	1	1	2	**1**
Not Applicable		6	102	6	77	15	53	31	11	9	
Summary											
Total Acceptable		105	38	96	33	68	65	85	73	81	**100**
Total Applicable		150	54	150	78	140	103	125	145	147	**155**
Percent Acceptable		**70%**	**70%**	**64%**	**42%**	**49%**	**63%**	**68%**	**50%**	**55%**	**65%**

CSR/Adult Status and Performance Profile - 6 Point Analysis

Current Practice Performance (Part 1 of 3)

Total Number	1. Engage. person	2a. Ser. team formation	2b. Ser. team function.	3. Assess. understand	4. Personal recovery	5a. Symptom SA redu	5b.. Recovery relapse	5c. Income benefits	5d. Sus. living supports
Unacceptable									
1	2	3	5	1	15	7	18	9	15
2	3	14	13	12	25	7	19	9	13
3	27	27	34	29	46	16	31	16	21
Acceptable									
4	35	33	46	37	36	44	39	33	33
5	83	73	52	67	32	68	35	67	54
6	6	6	6	8	1	3	1	5	4
Not Applicable						11	12	17	15
Summary									
Total Acceptable	124	112	104	112	89	115	75	105	91
Total Applicable	156	156	156	154	155	145	143	139	140
Percent Acceptable	**79%**	**72%**	**67%**	**73%**	**45%**	**79%**	**52%**	**76%**	**65%**

Current Practice Performance (Part 2 of 3)

Total Number	5e. Social integration	5f. Transition adjustment	6. Resources: avail.	6b. Resources: use	7. Intervention adequacy	8. Urgent response	9. Med. mgt.	10. Seclusion restraint
Unacceptable				no PT data				
1	12	16	1	2	4	5	2	
2	24	16	7	6	18	6	9	
3	45	30	29	24	32	10	5	
Acceptable								
4	34	34	44	28	60	9	33	
5	29	28	72	36	41	39	86	
6			3	4	1	1	14	
Not Applicable	12	32				86	7	156
Summary								
Total Acceptable	63	62	119	68	102	49	133	0
Total Applicable	144	124	156	100	156	70	149	
Percent Acceptable	**44%**	**50%**	**76%**	**68%**	**65%**	**70%**	**89%**	**?**

Current Practice Performance (Part 3 of 3)

Total Number	11. Support comm. int	12 Service coord. & contin.	13. Recov plan adjust.	14. Cultural accom.	**15. Overall System Perform.**
Unacceptable					
1	3	7	9		**3**
2	10	7	17	1	**14**
3	32	20	28	1	**26**
Acceptable					
4	49	37	50	8	**64**
5	33	79	50	31	**49**
6	2	5	2	4	
Not Applicable	26			109	
Summary					
Total Acceptable	84	121	102	43	**113**
Total Applicable	129	155	156	45	**156**
Percent Acceptable	**65%**	**78%**	**65%**	**96%**	**72%**

Child Status and Performance Profile - 6 Point Analysis

Number of cases: 144 — Combined Data

Status of the Child/Youth (Part 1 of 2)

		Total Number	1a. Child safety	1b. Safety others	2a. Stability: home	2b. Stability: school	3. Perman.	4. Living arrange.	5. Health/Phy well-being	6a. Emot/Beh w/b: home	6b. Emot/Beh w/b: sch
	Unacceptable										
	1						1				3
Improvement	2		2	1	9	9	6	2	4	11	11
	3		9	16	18	16	14	15	4	39	26
	Acceptable										
Refinement	4		35	37	45	36	28	36	36	68	56
	5		77	59	53	57	55	60	73	26	39
Maintenance	6		21	31	19	22	40	31	26		4
	Not Applicable					4					5
	Summary										
Total	Acceptable		133	127	117	115	123	127	135	94	99
Total	Applicable		144	144	144	140	144	144	143	144	139
Percent	Acceptable		**92%**	**88%**	**81%**	**82%**	**85%**	**88%**	**94%**	**65%**	**71%**

Status of the Child/Youth (Part 2 of 2)

		Total Number	7.. Sub use child/y	8a. Educat. place	8a. School attend.	8c. Instruct. engage.	8d. Present perform.	9. Social beh/supp.	10a Lawful beh ch/youth	10b. Lawful beh parent	**Overall Child Status**
	Unacceptable										
	1			7	5	18	6				
Improvement	2		1	4	6	13	27	12	2	2	**4**
	3		3	16	7	21	21	35	14	6	**27**
	Acceptable										
Refinement	4		5	21	12	36	41	55	18	8	**46**
	5		8	61	43	34	40	30	33	46	**66**
Maintenance	6		8	32	65	17	5	6	26	59	**1**
	Not Applicable		119	3	6	5	4	6	50	23	
	Summary										
Total	Acceptable		21	114	120	87	86	91	77	113	**113**
Total	Applicable		25	141	138	139	140	138	93	121	**144**
Percent	Acceptable		**84%**	**81%**	**87%**	**63%**	**61%**	**66%**	**83%**	**93%**	**78%**

Status of the Caregiver

Child Progress

		Total Number	1. Caregiv. support	12a. Par. cap present	12b. Par. cap reunify	13. C/giver participat.	14. Sub use caregiver	15a. Satis. child	15b. Satis. caregiv	**Overall Caregiver Status**	1a. Symptom reduction	1b. Sub use reduction
	Unacceptable											
Improvement	1				2	2		1	2		1	1
	2	4	5	3	3	3	2	2	**2**	6	1
	3	18	23	4	15	6	7	8	**16**	27	2
	Acceptable											
Refinement	4	43	54	3	51	9	25	22	**51**	55	2
	5	61	39	2	52	11	50	66	**63**	50	4
Maintenance	6	17	18	1	21	15	29	36	**12**		4
	Not Applicable		4	129		100	30	8		5	130
	Summary											
Total	Acceptable	121	111	6	124	35	104	124	**126**	105	10
Total	Applicable	143	139	15	144	44	114	136	**144**	139	14
Percent	Acceptable	**85%**	**80%**	**40%**	**86%**	**80%**	**91%**	**91%**	**88%**	**76%**	**71%**

Child Status and Performance Profile - 6 Point Analysis

Status of Child Progress (Part 2 of 2)

Practice Performance (Part 1 of 3)

Total Number	2. Improv. coping	3. Sch/wk progress	4. Risk reduct.	5a. Meaging. rela. family	5b. Meaging. rela. peers	5c. Meaging. rela. adults	6. Transit. progress	**Overall Progress**	1. Engage.	2a. Teamwork structure
Unacceptable										
1	2	4	2	1	1	2	6	**1**	1	4
2	5	20	8	4	19	7	7	**7**	6	22
3	35	26	21	15	29	16	14	**28**	15	40
Acceptable										
4	48	37	37	42	39	43	18	**53**	45	36
5	44	43	43	59	38	52	14	**54**	61	36
6	4	8	2	13	9	11	1	**1**	16	6
Not Applicable	6	6	30	9	9	13	84			
Summary										
Total Acceptable	96	88	82	114	86	106	33	**108**	122	78
Total Applicable	138	138	113	134	135	131	60	**144**	144	144
Percent Acceptable	**70%**	**64%**	**73%**	**85%**	**64%**	**81%**	**55%**	**75%**	**85%**	**54%**

Current Practice Performance (Part 2 of 3)

Total Number	2b. Teamwork functioning	3a. Assess child	3b. Assess family	4. Outcomes endings	5a. Symptom SA/reduce	5b. Behavior changes	5c. Sustainable supports	5d. Crisis response	5e. Recovery/ relapse.
Unacceptable									
1	4	2	3	4	1		9	5	3
2	27	10	8	22	5	7	19	15	5
3	40	21	35	37	23	30	39	17	12
Acceptable									
4	33	40	36	50	49	50	33	17	12
5	35	59	52	28	50	49	28	22	6
6	5	11	6	2	4	5	7	6	2
Not Applicable			3		11	2	9	62	104
Summary									
Total Acceptable	73	110	94	80	103	104	68	45	20
Total Applicable	144	143	140	143	132	141	135	82	40
Percent Acceptable	**51%**	**77%**	**67%**	**56%**	**78%**	**74%**	**50%**	**55%**	**50%**

Current Practice Performance (Part 3 of 3)

Total Number	5f. Transition independ.	6. Family support	7. Crisis response	8a. Resource unique/flex	8b. Resource unit/place	9. Adequacy interven	10. Tracking adjust.	**Overall Practice Performance**
Unacceptable								
1	10	2	4	1			2	
2	18	11	10	16	5	11	18	**11**
3	14	34	15	33	16	37	34	**46**
Acceptable								
4	18	37	13	35	13	35	38	**47**
5	12	43	17	27	38	55	40	**38**
6	3	7	4	7	6	6	12	**2**
Not Applicable	68	10	81	23	66			
Summary								
Total Acceptable	33	87	34	69	57	96	90	**87**
Total Applicable	75	134	63	119	78	144	144	**144**
Percent Acceptable	**44%**	**65%**	**54%**	**58%**	**73%**	**67%**	**63%**	**60%**

Appendix D: General Rating Scale Definitions

CSR Interpretative Guide for Consumer Status

Maintenance Zone: 5-6

Status is favorable. Efforts should be made to maintain and build upon a positive situation.

6 = **OPTIMAL STATUS**. The best or most favorable status presently attainable for this person in this area [taking age and ability into account]. The person doing great! Confidence is high that long-term goals or expectations will be met in this area.

5 = **GOOD STATUS**. Substantially and dependably positive status for the person in this area with an ongoing positive pattern. This status level is consistent with attainment of long-term goals in area. Status is "looking good" and likely to continue.

Acceptable Range: 4-6

Refinement Zone: 3-4

Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.

4 = **FAIR STATUS**. Status is minimally or temporarily sufficient for the person to meet short-term objectives in this area. Status is minimally acceptable at this point in time, but may be short-term due to changing circumstance, requiring change soon.

3 = **MARGINAL STATUS**. Status is marginal or mixed and not quite sufficient to meet the person's short-term objectives now in this area. Status now is not quite enough for the person to be satisfactory today or successful in the near-term. Risks are minimal.

Improvement Zone: 1-2

Status is now problematic or risky. Quick action should be taken to improve the situation.

2 = **POOR STATUS**. Status continues to be poor and unacceptable. The person seems to be "stuck" or "lost" and status is not improving. Risks are mild to moderate.

1 = **ADVERSE STATUS**. The person's status in this area is poor and getting worse. Risks of harm, restriction, separation, regression, and/or other poor outcomes are substantial and increasing.

Unacceptable Range: 1-3

CSR Interpretative Guide for Consumer Performance

Maint. - Green Zone: 5-6

Performance is effective. Efforts should be made to maintain and build upon a positive practice situation.

6 = **OPTIMAL PERFORMANCE**. Excellent, consistent, effective practice for this person in this function area. This level of performance is indicative of exemplary practice and results for the person. ["Optimum" does not imply "perfection."]

5 = **GOOD PERFORMANCE**. At this level, the system function is working dependably for this person, under changing conditions and over time. Effectiveness level is consistent with meeting long-term goals for the person. [Keep this going for good results]

Acceptable Range: 4-6

Refine. - Yellow Zone: 3-4

Performance is minimal or marginal and maybe changing. Further efforts are necessary to refine thepractice situation.

4 = **FAIR PERFORMANCE**. This level of performance is minimally or temporarily sufficient for the person to meet short-term objectives. Performance may be time-limited or require adjustment soon due to changing circumstances.[Some refinement is indicated]

3 = **MARGINAL PERFORMANCE**. Practice at this level may be under-powered, inconsistent, or not well-matched to need. Performance is insufficient for the person to meet short-term objectives. [With refinement, this could become acceptable in the near future.]

Improve. - Red Zone: 1-2

Performance is inadequate. Quick action should be taken to improve practice now.

2 = **POOR PERFORMANCE**. Practice at this level is fragmented, inconsistent, lacking in intensity, or off-target. Elements of practice may be noted, but it is incomplete/not operative on a consistent basis.

1 = **ADVERSE PERFORMANCE**. Practice may be absent or not operative. Performance may be missing (not done). - OR - Practice strategies, if occurring in this area, may be contra-indicated or may be performed inappropriately or harmfully.

Unacceptable Range: 1-3

CSR Interpretative Guide for Child & Caregiver Status

Maint. - Green Zone: 5-6

Status is favorable. Efforts should be made to maintain and build upon a positive situation.

6 = **OPTIMAL STATUS**. The best or most favorable status presently attainable for this child/caregiver in this area [taking age and ability into account]. The child/caregiver are doing great! Confidence is high that long-term goals or expectations will be met in this area.

5 = **GOOD STATUS**. Substantially and dependably positive status for the child/caregiver in this area with an ongoing positive pattern. This status level is consistent with attainment of long-term goals in area. Status is "looking good" and likely to continue.

Acceptable Range: 4-6

Refine. - Yellow Zone: 3-4

Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.

4 = **FAIR STATUS**. Status is minimally or temporarily sufficient for the child/caregiver to meet short-term objectives in this area. Status is minimally acceptable at this point in time, but may be short-term due to changing circumstance, requiring change soon.

3 = **MARGINAL STATUS**. Status is marginal or mixed and not quite sufficient to meet the child/caregiver's short-term objectives now in this area. Status now is not quite enough for the child/caregiver to be satisfactory today or successful in the near-term. Risks are minimal.

Improve. - Red Zone: 1-2

Status is now problematic or risky. Quick action should be taken to improve the situation.

2 = **POOR STATUS**. Status continues to be poor and unacceptable. The child/cargiver seems to be "stuck" or "lost" and status is not improving. Risks are mild to moderate.

1 = **ADVERSE STATUS**. Child/caregiver status in this area is poor and getting worse. Risks of harm, restriction, separation, regression, and/or other poor outcomes are substantial and increasing.

Unacceptable Range: 1-3

CSR Interpretative Guide for Practice Performance

Maint. - Green Zone: 5-6

Performance is effective. Efforts should be made to maintain and build upon a positive practice situation.

6 = **OPTIMAL PERFORMANCE**. Excellent, consistent, effective practice for this child/caregiver in this function area. This level of performance is indicative of exemplary practice and results for the child/caregiver. ["Optimum" does not imply "perfection."]

5 = **GOOD PERFORMANCE**. At this level, the system function is working dependably for this child/caregiver, under changing conditions and over time. Effectiveness level is consistent with meeting long-term goals for the child. [Keep this going for good results]

Acceptable Range: 4-6

Refine. - Yellow Zone: 3-4

Performance is minimal or marginal and maybe changing. Further efforts are necessary to refine thepractice situation.

4 = **FAIR PERFORMANCE**. This level of performance is minimally or temporarily sufficient for the child/caretiver to meet short-term objectives. Performance may be time-limited or require adjustment soon due to changing circumstances.[Some refinement is indicated]

3 = **MARGINAL PERFORMANCE**. Practice at this level may be under-powered, inconsistent, or not well-matched to need. Performance is insufficient for the child/caregiver to meet short-term objectives. [With refinement, this could become acceptable in the near future.]

Improve. - Red Zone: 1-2

Performance is inadequate. Quick action should be taken to improve practice now.

2 = **POOR PERFORMANCE**. Practice at this level is fragmented, inconsistent, lacking in intensity, or off-target. Elements of practice may be noted, but it is incomplete/not operative on a consistent basis.

1 = **ADVERSE PERFORMANCE**. Practice may be absent or not operative. Performance may be missing (not done). - OR - Practice strategies, if occurring in this area, may be contra-indicated or may be performed inappropriately or harmfully.

Unacceptable Range: 1-3

Appendix E:
Design Team Participants and CSR Reviewers

Division of Mental Health and Addiction
Protocol Development

Youth Protocol Development Team
January 24 - 26, 2006

Beckham	Roxanne	Southwestern	Vice President Operations
Broom	Gayle	Midtown Community Mental Health Center	Clinician I
Dearing	Kate	Northeastern Center	
Effland	Vicki	Choices	Director of Outcomes & Evaluation
Hamm	Chris	Cummins Behavioral Health Services	Vice President for Clinical Services
Jones	Shannon	Southwestern IN MHC	Psychiatrist
Miller	Suzanne	Johnson County Probation	
Piper	Patrick	Richmond State Hospital	Recreational Therapist
Ruhrold	Richard	Bowen Center	Vice President for Clinical Services
Rupp	Julia	Community Mental Health Center	COO for Clinical Services
Washburn	Deborah	NAMI Indianapolis	Family Advocate

Adult Protocol Development Team
January 31 - February 2, 2006

Blackmon	Sirilla	Midtown Community Mental Health Center	Director of Regulatory Services
Born	Dennis	SECT Center	SECT Director
Cole	Judy	Richmond State Hospital	
Markley	Susan	Dunn Mental Health Center	Chief of Adult Services
Matsey	David	Starke Circuit Court	Judge
Rector	Bruce	Meridian Services	Supervisor
Roberts	Terri	Park Center	Total Quality Coordinator
Salyers	Michelle	IUPUI - ACT Center	Director, ACT Center
Sartor	Cynthia	Hamilton Center	
Sheth	Ashvin	Edgewater Systems	Vice President, Clinical Services
Sigafus	Becca	InteCare	Director of Quality Improvement
Talbott	Tom	Community Mental Health Center	Director of Perf Improv & Info Mgmt
VanDusen	Bruce	Midtown Community Mental Health Center	Director of Midtown Crossing

Indiana Reviewer Training List

	Last Name	First Name	Facility	Title	City	State	May	Sep	Oct	Nov	Dec
A	Albers	Donna	Swanson Center	Clinical Chief of Operations	Michigan City	IN	R/S		R/S		
Y	Baldwin	Dan	Swanson Center	LCSW	Michigan City	IN				R/S	
Y	Bauermeister	Kelly	Quinco Behavioral Health Systems	LCSW			R/S		R/S		
A	Blackmon	Sirrilla	Midtown Community Mental Health Center	Director of Regulatory Services	Indianapolis	IN					
A	Born	Dennis	Center for Mental Health Inc	SECT Center Manager	Anderson	IN	S	R/S		R/S	R
A	Boyle	Charles	DMHA	Bureau Chief	Indianapolis	IN	S	R/S		R	R/S
A	Brodhead	Sally	Meridian Services Inc.	Outpatient Manager	Muncie	IN		R	R/S		
A	Brown	Beverly	Samaritan Center	Asst Dept. Dir,Adult Serv					S		
A	Brown	Pat	Otis R Bowen Center for Human Services Inc		Warsaw	IN	R/S			R	
A	Burns	Margie	Park Center Inc					R/S			
Y	Campbell	Jennifer	Department of Education				R/S				R
Y	Carlson	Sandy	Porter Starke Services Inc	Vice President, Clinical Services	Valparaiso	IN					
Y	Carrico	Lisa	Larue Carter	Youth Division Director	Indianapolis	IN					
A	Chen	Steven	Community Addiction Services of IN	Organization Consultant	Indianapolis	IN					
A	Clark	Greg	Center for Behavioral Health		Bloomington	IN					
Y	Conway	Beth	Otis R Bowen Center for Human Services Inc	Child/Adolescent Case Manager Team Leader	Albion	IN				R/S	
Y	Coulon	Angela	DCS	Policy and QA Manager	Indianapolis	IN					
Y	Daniels	Leslie	Southlake Center for Mental Health Inc								
A	Davis	Bill	Howard Community Hospital Psychiatric Services	Director, Community Support Services	Kokomo	IN	R/S				R/S
Y	Davis	Doug	BehaviorCorp	Coordinator for Children's Services	Carmel	IN				R	R/S
A	Davis	Lesly	BehaviorCorp	Assoc. Dir of Corporate Compliance & QI	Carmel	IN			R/S		
A	Dearing	Kathleen	Northeastern Center	Quality Control/Survey Coordinator	Kendallville	IN					S
A	DeQuis	Kimberly	Vocational Rehabilitation Services	Area Supervisor	Elkhart	IN					
A	Disori	Francis	Oaklawn Psychiatric Center Inc				R/S				R/S
A	Fawcett	Donna	Lifespring, Inc.	Vice President, Adult Services	Jeffersonville	IN			S		
Y	Fisher	Pat	BehaviorCorp	Supervisor	Indianapolis	IN				R/S	
A	Flaherty	Patricia	Adult & Child Mental Health Center Inc							R/S	
A	Franko	Bob	Porter Starke Services Inc	Development Director	Valparaiso	IN	R/S				R
A	Freeland	Leah	Quinco Behavioral Health Systems	LMHC					R/S		
A	Garner	Dave	DMHA	Program Director	Indianapolis	IN					
A	Gearhart	Tim	ACT Center	IMR Consultant/Trainer	Indianapolis	IN	R		R		
Y	Goldberg-Mitton	Lisa	Choices, Inc.	Program Supervisor	Indianapolis	IN		R/S			
A	Grissom	Jeannette	DMHA	Consultant	Indianapolis	IN				S	
Y	Hamm	Chris	Cummins Behavioral Health Systems	Vice President for Clinical Services	Avon	IN					
A	Hamm	Chris	Cummins Behavioral Health Systems	Vice President for Clinical Services	Avon	IN					
Y	Hartley	Linda	Park Center Inc	Manager	Ft Wayne	IN				R	
A	Haviza	Dan	Southwestern Indiana Mental Health Center Inc	Inpatient Coordinator	Evansville	IN	R/S				
A	Hedden	Lindsay	Four County Counseling Center	Training Cooridnator	Logansport	IN	S			S	
A	Hedelius	Carl	Cummins Behavioral Health Systems	Clinical Services Coordinator					S		
A	Heeter	Eric	Larue Carter Hospital	Adult Services Director	Indianapolis	IN				R/S	
A	Hein	Randall	Madison Center Inc	Team Leader	South Bend	IN	R/S				
Y	Helstern	Nancy	Four County Counseling Center		Rochester	IN					R/S
Y	Henry-Baker	Roberta	DMHA	Consultant	Indianapolis	IN			R/S		
Y	Hersch	Jessica	Center for Behavioral Health		Bloomington	IN			R		
Y	Hill	Mark	Samaritan Center	Director of C&A services			R			R	
Y	Houchins	Kent	Hamilton Center Inc	Division Director	Linton	IN				R/S	
Y	Howell	Steve	Northeastern Center		Kendallville	IN		R/S			
Y	Huddleston	Dianna	Wabash Valley Hospital Inc	Dir of Comm Living for Child & Adol	West Lafayette	IN				R/S	
A	Jaeger	Susan	ACT Center	IMR Project Manager	Indianapolis	IN	R/S	R			
Y	Johnson	Tina	Gallahue Mental Health Center						R/S		
A	Keesling	Barb	Vocational Rehabilitation Services	Voc Rehab Counselor	Marion	IN					

Indiana Reviewer Training List

	Last Name	First Name	Facility	Title	City	State	May	Sep	Oct	Nov	Dec
Y	Kennedy	John	Choices, Inc.	Director, Youth Emergency Services	Indianapolis	IN					R/S
Y	Ketner	Melissa	Adult & Child Mental Health Center Inc	Case Manager	Indianapolis	IN		R/S			
A	Kimani	Steve	Edgewater Systems for Balanced Living Inc	Vice President, Quality Mgt.	Gary	IN			S		
Y	Kixmiller	Jana	Lifespring, Inc.	Vice President For Children & Family Services	Jeffersonville	IN	S		R		R
A	Ladowicz	Denise	Tri City Comprehensive CMHC Inc	Service Director, Community Support Services	East Chicago	IN	S		R		
A	Loheide	Bob	Hamilton Center Inc	Psy.D, HSPP	Terre Haute	IN				R/S	
A	Lummus	Sue	DMHA	Deputy Director	Indianapolis	IN		R/S			
Y	Marvel	Greg	Dunn Mental Health Center	Director, Children & Family Services			S	R/S			
Y	McAlister	Scott	Otis R Bowen Center for Human Services Inc		Ft Wayne	IN	R/S	R			
A	McClain	Linda	Gallahue Community Mental Health Center	Education Coordinator/Quality Specialist	Indianapolis	IN				S	
Y	McGuckin	Debra	Howard Community Hospital Psychiatric Services		Kokomo	IN	R/S			R	
Y	McIntyre	Janet	Choices, Inc.	Director, Technical Assistance & Training			R			S	
Y	Meadows	Leslie	Cummins Behavioral Health Systems	UM-UR Coordinator						S	
Y	Miller	Andrea	Southwestern Indiana Mental Health Center Inc	Community Support Services Coordinator	Evansville	IN	S		R	R/S	
A	Mills	Vicki	Wabash Valley Hospital Inc	Director, Community Living Program	Lafayette	IN					
Y	Navarro	Daniel	Midtown Community Mental Health Center	Clinical Supervisor	Indianapolis	IN					R/S
A	Nickerson	Derrell	Edgewater Systems for Balanced Living Inc	Director of Addiction Services	Gary	IN			S		
A	Noonan	Jennifer	Southlake Center for Mental Health Inc	Supervisor, Partial Hospitalization Program	Merrillville	IN			R/S		R
Y	Pew	Kenneth	MHA in Henry County	Executive Director	New Castle	IN					
Y	Piper	Patrick	Richmond State Hospital	Recreational Therapist	Richmond	IN					
A	Reed	Jan	DDRS - VRC Office								
Y	Robinson	Emily	Madison Center Inc				R/S			R/S	
Y	Roseberry	Mary Jo	Meridian Services Inc.	Division Director	Muncie	IN		R	R/S		
A	Rupp	Carol	Logansport State Hospital	Social Worker	Logansport	IN		R/S			
Y	Rupp	Julia	Community Mental Health Center Inc	Chief Operating Officer for Clinical Services	Lawrenceburg	IN					R/S
A	Scalf	Tonya	Grant Blackford Mental Health Inc	MSW	Marion	IN		R/S			
Y	Schrock	Bonita	Oaklawn Psychiatric Center Inc				R/S				
A	Scotten	Tammy	Dunn Mental Health Center	Director, Comm Support Sys				R/S			R
Y	Shearer	Cheryl	DMHA	Community Consultant	Indianapolis	IN	S		R		R
A	Sigafus	Becca	InteCare	Director of Quality Improvement	Indianapolis	IN			R/S		
Y	Skeel	Jim	Center for Mental Health Inc	Clinical Director of Outpatient Services			S		R		
Y	Sproatt	Patsy	DCS	Policy Specialist	Indianapolis	IN					S
A	Stauffer	Ron	Southern Hills Counseling Center	Outpatient Coordinator	Tell City	IN			R		
A	Stout	Jami	Vocational Rehabilitation Services	Area Supervisor	Columbus	IN					
A	Talbot	Tom	Community Mental Health Center Inc	Dir of Perf Improv & Info Mgt	Lawrenceburg	IN	R/S	R			
Y	Thomas	Tim	Edgewater Systems for Balanced Living Inc	Director of Family and Youth	Gary	IN	S		R/S	R	
A	Toomer	Tony	DMHA	Community Consultant	Indianapolis	IN	R/S	R/S	R/S	R	R/S
A	VanDussen	Bruce	Midtown Community Mental Health Center						R/S		
A	Viernes	John	DMHA	Deputy Director	Indianapolis	IN		R/S	R	R	
Y	Villirreal	Julie	Southlake Center for Mental Health Inc	Clinical Supervisor	Merrillville	IN					
A	Walls	Barb	Four County Counseling Center	Acute Care Unit Coordinator	Logansport	IN					
Y	Walton	Betty	DMHA	Consultant	Indianapolis	IN		R/S			
Y	Washburn	Deborah	NAMI Indianapolis	Chair, Children's Committee	Zionsville	IN				R/S	
A	Werich	Greg	Wells County Probation								
A	Wheeler	Kirk	InteCare	Director of Clinical Operations	Indianapolis	IN			R/S		
Y	Whitaker	Lisa	DCS	Quality Assurance Specialist	Indianapolis	IN				S	
A	Williams	Fred	Vocational Rehabilitation Services	Area Supervisor	Lafayette	IN					
Y	Zagorka	James	Tri City Comprehensive CMHC Inc								

Y: Youth
A: Adult

R: Reviewer
S: Shadow

CMHC staff
Other (including other state agency staff)
DMHA staff (including State Hospital Staff)
Consumer or Family member

External Reviewers Provided by HSO
2006

September 18-22 – 12 reviewers

Kids		Adults	
1	Kate Gibbons	1	Susan Curran
2	Carol Thomas	2	John Gates
3	Gwyn Ingle	3	Celeste Putnam
4	Jerry Glover	4	Linda Radigan
5	Mary Brogan	5	Erica Heintz
6	Jim Efstation	6	Jo Schaden

October 16-20 – 12 reviewers

Kids		Adults	
1	Gwyn Ingle	1	Kate Gibbons
2	Burt Wheeler	2	Celeste Putnam
3	Tom Keane	3	Linda Radigan
4	Jerry Glover	4	Philip Lucas
5	Cathy Joseph	5	Jo Schaden
6	Jim Efstation	6	Sharon Cantrell

November 13-17 – 8 reviewers

Kids		Adults	
1	Kate Gibbons	1	Susan Curran
2	Tom Keane	2	Celeste Putnam
3	Juanita Iwamoto	3	Linda Radigan
4	Gayle Samuels	4	Mike Franczak

December 11-15 – 7 reviewers

Kids		Adults	
1	Kate Gibbons	1	Susan Curran
2	Gwyn Ingle	2	John Gates
3	Jim Efstation	3	Celeste Putnam
		4	Philip Lucas